



ENT Associates of Worcester

Sinus • Hearing • Allergy

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Medical Records Request

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize ENT Associates of Worcester, Inc. to use and/or disclose my protected health information (PHI) as described below. I understand that this authorization is voluntary and that I may revoke it at any time except to the extent that action has already been taken in reliance on this authorization.

Patient Name		Date of Birth	
Phone Number		Medical Record # (if known)	
Address		City/State/Zip	
Email		Date	

I AUTHORIZE THE ABOVE-MENTIONED HEALTH INFORMATION TO BE RELEASED FROM:

Facility / Provider Name	
Address	
Phone	
Fax	

TO BE RELEASED TO:

VIA Fax Mail Pick Up

Facility / Provider Name	
Address	
Phone	
Fax	

Information to be released (check all that apply):

- Office Notes Operative Reports Lab Results Imaging Reports Billing Records
 Complete Medical Record

Purpose of Request: _____

I understand that the information released may include information relating to HIV, AIDS, mental health, genetic testing, and/or substance abuse treatment unless otherwise specified.

Signature of Patient / Legal Representative	Date

Relationship to Patient (if not patient): _____