



**SUPERIOR**  
 Ear, Nose & Throat  
 Allergy & Audiology

*Philip D. Heichel, MD*

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize: Name \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

To release the following medical information to:

Superior Ear Nose and Throat Specialists, P.C.  
 712 Chippewa Square, Suite 100  
 Marquette, MI 49855  
 Fax Number: (906) 225-7665

\_\_\_\_\_ Any and all of my medical records.

\_\_\_\_\_ Only the following medical records \_\_\_\_\_

This release also specifically allows the release of the following medical records that **will not** be released unless initialed:

\_\_\_\_\_ Any record of treatment for drug and/or alcohol abuse.

\_\_\_\_\_ Any record of mental health treatment

\_\_\_\_\_ Any record of testing, care, treatment, reporting or research pertaining to infection of HIV or related diseases.

This release is effective for six months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the Office Manager.

Patient/Representative Signature: \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_