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 _____