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Date: _____

Account # _____

Patient's Name _____

Date of Birth _____

Telephone # _____

AUTHORIZATION TO RELEASE/PICK UP MEDICAL RECORDS

From:
Carlson Ear Nose & Throat
3172 N. Swan Rd.
Tucson, AZ 85712

To: _____

Phone: _____
Fax: _____

INFORMATION TO BE RELEASED _____

REASON FOR RELEASE OF RECORDS _____

**I, undersigned, consent to the release of medical information (records).
THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE after one year
from the date of signing. The undersigned may revoke this authorization at any time
by providing written notice of revocation.**

Signature of Physician

Date signed

Signature of Patient/Legal Rep.

Date signed