CARLSON
EAR NOSE & THROAT ASSOCIATES

James R. Carlson, M.D., M.B.A. **Stephanie C. Carlson, R.N., CNOR**

3172 N. Swan Rd.
Tucson, AZ 85712
(520) 795-8777
(520) 795-8787 Fax

1521 E. Tangerine Rd., Suite 225
Oro Valley, AZ 85755
(520) 797-8789
(520) 797-8787 Fax

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