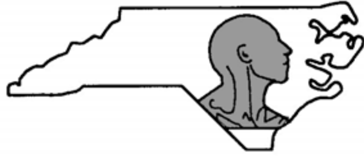

Carolina Ear, Nose & Throat
Head and Neck Surgery Center, PA
304 10th Avenue NE
Hickory NC 28601
(828) 322-2183
Fax (828) 328-2838
www.carolinaearnosethroat.com

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name____

Patient Address____

____

D.O.B.__________________________________SS#______________________________

I do hereby consent and authorize you to release copies of my medical records. This will include any records related to medical care provided by Carolina ENT/HNSC and or tests/services ordered by Carolina ENT/HNSC. This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to HIV testing, AIDS and any AID-related syndromes. It also includes any information concerning cancer testing and results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of requested information to the address listed below.

Dates of Service:____

Records are requested from:____

Records can be mailed to:____

Records can be faxed to:____

______________________________ _________________________
Signature of Patient/ Legal Guardian Date

______________________________ _________________________
Witness Date

This information is strictly CONFIDENTIAL AND PRIVILEGED. This form requires a signature please mail or fax upon completion.

HICKORY LENOIR LINCOLNTON DENVER MOORESVILLE