

COLORADO WEST OTOLARYNGOLOGISTS, P.C.
425 PATTERSON, SUITE 503
GRAND JUNCTION, CO 81506
970-245-2400
970-242-9092 FAX

PATIENT IDENTIFICATION:

RELEASE TO:

Name

Name

Social Security #

Address

Birth Date

City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Colorado West Otolaryngologists, P.C. to release my medical records to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Colorado West Otolaryngologists, P.C, my physician and all CWO personnel from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: () Please initial. Specifically authorize the release of the following information.

- Alcohol and/or Drug Abuse, if any
- HIV/AIDS Status, if any
- Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

- Copies of hospital History & Physical, Discharge Summary, Operative Reports
- Copies of imaging studies
- Copies of office visits
- Copies of audiograms
- Copy of complete chart
- Other
(specify): _____

A copy of this authorization may be utilized with the same effectiveness as an original.

Signature of Patient or Parent/Legally
Authorized Person

Printed name of person authorized to
sign for patient

Date

How authorized

Records released by: _____ Date: _____