INSPIRE
ENT & PULMONOLOGY

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MEDICAL RECORDS RELEASE

Patient's name: _____

Patient's date of birth: _____

The undersigned hereby authorizes and requests:

Dr. _____ at (Clinic/Facility) _____

Address: _____

City, State, Zip Code: _____

Fax: _____ Phone: _____

To release patient's records to:

Dr. _____

at (clinic/facility) _____

City, State, Zip Code: _____

Fax: _____ Phone: _____

Please release the following records:

Address: _____

☐ All Records ☐ Labs ☐ X-Rays ☐ Other (please specify) _____

I understand that my medical records (including any psychiatric, alcohol or drug use information) may be protected by Federal Regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below.
I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Restrictions: We can only copy medical records that have been originated through this authorization.
This authorization shall be valid for one year unless otherwise specified.

SPECIFICATIONS OF THE DATE, EVENT OR CONDITION UPON WHICH THIS CONSENT EXPIRES:

(If left blank this consent expires in one year): _____

_____ _____
Signature of Patient Date

_____ _____
Witness Date