Authorization to release medical records

Patient Name _____
(Last) (First) (M.I)

Address_____
(Street) (City) (State) (WI)

Phone _____ Birthdate _____

I authorize _____ to release my Medical Records to:

Alliance ENT and Hearing Center, SC

201 N Mayfair Rd, Suite 515

Wauwatosa, WI 53226

Phone: 414-727-0910, Fax: 414-727-0920

Please release:

- o **Entire Record**
- o **Specific Information _____**
  _____

Reason for request:_____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time.

SIGNED_____ DATE_____

(If not the patient, State relationship)