Ear, Nose & Throat Associates of Nassau County

2870 Hempstead Tpke. #203, Levittown, NY 11756 (516) 731-6644 FAX 731-8746
165 N. Village Ave. #117, Rockville Centre, NY 11570 (516) 764-1055 764-1062
333 Glen Head Road #110, Old Brookville, NY 11542 (516) 671-5511 671-5210

AUTHORIZATION FOR RELEASE OF MEDICAL AND HEALTHCARE INFORMATION

_____
(Patients Name)

Date of Birth_____ SS#_____

Please check and initial appropriate request.

1)_____For release of records to Ear, Nose & Throat Associates of Nassau County
_____ 2870 Hempstead Tpke. #203 Levittown, NY 11756
_____ 165 N. Village Ave. #117, Rockville Centre, NY 11570
_____ 333 Glen Head Rd. #110, Old Brookville, NY 11542

2)_____Patient requests copy of their medical records for personal use.

3)_____To release the following information to:_____

75¢ A PAGE
WILL CALL WHEN READY

_____

_____

_____ Entire Record _____Progress Notes _____Lab Tests _____Radiology Reports

_____ Other (explain)_____

THIS AUTHORIZATION REFERS TO INFORMATION DATED FROM_____TO_____.

The patients' medical records are being requested for the purpose of enhancing medical care. This authorization is valid for 120 days from the date of signature. The patient can revoke this authorization at any time by notifying Ear, Nose & Throat Associates of Nassau County in writing. The patient agrees that a copy of this authorization may be considered valid authorization.

Patients Signature_____Date_____

** 48 hrs. Notice **