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Potomac Ear, Nose & Throat, PLLC

Authorization for Disclosure of Medical Records

Regarding Patient: **COMPLETE IN FULL**

Last Name	First name	Middle	Date

Date of Birth	Phone Number	Cell Phone

Street Address

City	State	Zip

Records Released To:

Last Name	First name	Middle

Phone Number	Fax Number

Street Address

City	State	Zip

Information to be released: **(circle all applicable categories)**

Complete Copy of all Records
Allergy Records
Labs Reports
Consultation Visits
Operative Reports
Immunization Records
Radiology Report
Audiologist Report
Clinic Records Pertaining to Specific Treatment: _____
Clinic Records Pertaining to Specific Date Range: _____
Other (Specify): _____

I authorize release of me medical records from Potomac Ear, Nose & Throat in accordance with the specification listed above. **I understand that I have to right to inspect and receive a copy of the disclosed material at a cost of $10.00 administration fee, $0.50 per page for the first 50 pages.** These charges are in accordance with the **VA code §8.01-413**.

Please allow 3-5 business days for the records to be copied and released.
A photocopy of this consent shall be valid as the original.

Signature: _____ Date: _____

Office use: $10.00 Administration Fee
$0.50 X _____ pages = $_____
$0.25 X _____ pages = $_____

TOTAL: $ _____