Authorization to Release Medical Information

Ear Nose & Throat Family Clinic of Wisconsin, S.C.
H. Swerdlin, M.D. – Board Certified Otolaryngologist – Head and Neck Surgeon
6127 Green Bay Road Suite 100, Kenosha, WI 53142
1101 South Airline Road, Racine, WI 53406
Phone (262)- 652-2887 Fax (262)-925-0238

I, _____ or _____
Patient Name (please print) Authorized Person (please print)

Address: _____ Phone: _____

Hereby authorize: _____
_____
_____
(P)_____(F)_____

To release to: Ear Nose & Throat Family Clinic of Wisconsin, S.C.
6127 Green Bay Road Suite 100
Kenosha, WI 53142

The following medical records relating to (check all that apply):
___ Medical/Surgical Condition ___ Psychiatric Illness ___ All Medical Records
___ Alcohol/ Drug Abuse ___ Lab/ X-ray ___ Other (please specify)

From the medical record of _____ _____
Patient name (please print) Date of Birth

**The above information is being released for the purpose of: (please specify) continuing medical treatment, reimbursement purposes, legal purposes, worker's compensation claim, ect, …

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent the disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician.

If not revoked, this authorization **will expire on** _____ **(**please specify) or ninety days after the date below, or sooner at my election.

I hereby release **Ear Nose & Throat Family Clinic of Wisconsin, S.C.** from any and all legal responsibility or liability that may arise from the disclosure or release of the information described above, including all liability for an alleged violation of having this information maintained in confidence and privacy.

_____ _____
Date Signature

_____ _____
Relationship to Patient Witness