Authorization to Release Medical Information

Patient:____

Date of Birth:_________________________ Social Security No.:________________________

The undersigned authorizes: ____

(Name of Health Care Provider, Hospital, etc.)

____

(Street Address)

____

(City, State, & Zip Code)

to disclose & deliver to:

Los Angeles Ear, Nose & Throat Associates
1245 Wilshire Boulevard, Suite 603
Los Angeles, California 90017

☐ All medical records in your possession.
☐ ____

Authorization:

☐ Patient:____

☐ Other:____ __________________________

(Relation to Patient)

Witnessed by:_______________________________________ Date:____________________