DESOTO
ear • nose • throat

5960 Getwell Road, Suite 212-D
Southaven, MS 38672
o 662.895.6455
f 662.895.6460

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name_____

Social Security Number:_____ DOB:_____

Release Records From:

_____

_____

_____

_____

Send Records To:
DeSoto Ear, Nose, and Throat
5960 Getwell Road, Suite 212 D
Southhaven, Ms 38672
662-895-6455, fax: 662-895-6461

Healthcare Coverage Period from:_____to:_____

Health Records requested:

( ) Progress Notes
( ) Lab
( ) Radiology Reports
( ) Other_____

I understand that specific information to be released may include AIDS or HIV, Alcohol, and/or Drug Abuse and Mental Health issues. I accept responsibility for the release of these documents and information contained herein. Unless otherwise indicated, this authorization will expire one year from the date of this signature. DeSoto Ear, Nose, and Throat and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____

Signature Relationship Date