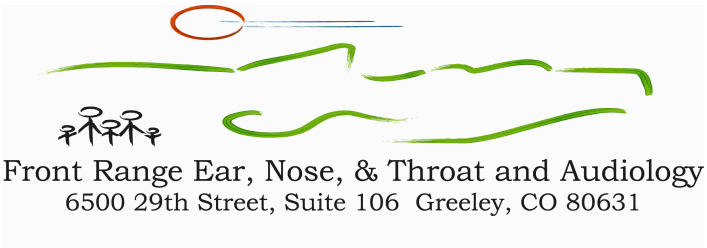

Front Range Ear, Nose, & Throat and Audiology
6500 29th Street, Suite 106 Greeley, CO 80631

Consent for Release of Medical Records

I, _____, hereby authorize the staff of Front Range ENT & Audiology to disclose or receive the following health information that pertains to:

Patient Name:_____

Date of Birth:_____

Today's Date: _____

Phone #: _____

***_____
Signature of patient or legal representative

__I request that _____send my medical records to the following location with the understanding that I have requested the disclosure of my health information.

Purpose: ___Transfer of care ___other _____
Please select one or more of the following:

___ Sent to:
Front Range ENT
6500 29th St, Suite 106
Greeley, CO 80634
Tel.#: 970-330-5555
Fax#: 970-584-1055

___ Send to:
_____

_____

_____

My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

*To take part in a research study. Or

*To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above names practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two way to revoke this authorization are:

*Fill out revocation form. The form is available from this office, Or

*Write a letter to the office.

One the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.