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CONSENT FORM FOR RELEASE OF MEDICAL INFORMATION

I, _____ (Patient Name) do hereby consent and authorize the disclosure of **all** medical records in the possession of the provider including, but not limited to records, reports or tests concerning alcoholism, drug use, emotional illness, psychiatric or mental disorders, abortions, symptoms or treatment of AIDS (Acquired Immune Deficiency Syndrome) including test results for the presence of HIV or an antibody to HIV.

If you wish to limit the material disclosed above in any way, please indicate exactly what you do not want released. There is no guarantee that identifiable health information will not be redisclosed by a recipient.

_____
(Name of Provider)

_____
(Address of Provider)

To disclose all of provider's records and information **to** Alamance Ear, Nose and Throat LLP
_____ PO Box 2, Burlington, NC 27216; 4030 Oaks Professional Parkway, Suite 201 Burlington, NC 27215 and/or _____ 3940 Arrowhead Blvd., STE 210, Mebane, NC 27302

All of my records and information **from** Alamance Ear, Nose and Throat LLP _____ PO Box 2, Burlington, NC 27216; 4030 Oaks Professional Parkway, Suite 201 Burlington, NC 27215 and/or _____ 3940 Arrowhead Blvd., STE 210, Mebane, NC 27302 to:

_____
(Name of Provider / Person/Self)

_____
(Address of Provider / Person/Self)

Patient's / Guardian Signature: _____ Date: _____
Date of Birth: _____ Telephone: _____
Account or Social Security # _____ Document expiration: _____

Office use:	**Scan into EMR and PM**	**Disclosure reason:**
Picture ID Verified:		**Signature Verified:**

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