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ENT ASSOCIATES OF NORTHERN COLORADO AND THE HEARING AND BALANCE CLINIC

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

I hereby consent to the release and disclosure of my personal health information:

To/From:	**To/From:**
ENT Associates of Northern Colorado	______________________
The Hearing and Balance Clinic	______________________
2121 E. Harmony Road Suite 350	______________________
Fort Collins, CO 80528	______________________
Ph: 970-484-6373	______________________
Fax: 970-484-0382	______________________

This release authorization includes my personal health information consisting of:

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I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of Ear, Nose & Throat Associated of Northern Colorado, P.C. having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

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Patient Name **Patient DOB**

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Patient / Guardian Signature **Relationship** **Date**