



Established 1975

Eastern Oklahoma Ear, Nose & Throat, Inc.

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

DATE: _____

PATIENT: _____ DATE OF BIRTH: _____
(PLEASE PRINT)

I, _____, hereby authorize Eastern Oklahoma Ear, Nose & Throat to release photocopies of my medical records to the following individual.

Release to: _____

Obtain From: _____

I further release EOENT from the responsibility for any deleterious effect the review of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution, and interpretation of medical information contained therein and hold blameless EOENT for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

I realize by the receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

By state law, you must be advised that:
The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

Signature of Patient/Guardian _____

Relationship: _____ Date: _____

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Ear, Nose & Throat
Medicine & Surgery*

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*Snoring & Sleep
Disorder Treatment*

*Skull Base, Facial, Plastic &
Reconstructive Surgery*

Head & Neck Surgery

*Medical & Surgical Treatment of
Hearing Loss, Balance & Facial
Nerve Disorders*

*Hearing Evaluation,
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