CONSENT FOR RELEASE OF MEDICAL RECORDS
TO ENT ASSOCIATES OF CENTRAL PA, PC

R. Charles Howells, MD, FACS, Robert J. Caughey, MD, David E. Higgins, MD, Kara E. Kimberly, MD
3341 Beale Avenue Logan Office Center Altoona, PA 16601
814-944-5357 (Phone) 814-946-8017 (Fax)
www.entcpa.com

I hereby authorize _____

To release the records of _____
Patient's Name (PRINT First, MI, Last) Date of Birth

Release Records to: ENT ASSOCIATES OF CENTRAL PA, PC

The purpose of the request is:

_____Patient Care _____Insurance _____Workers Compensation

_____Military _____Disability _____Patient Request _____Other

Information to be released (Itemized portions of record and time period):

_____

_____

I authorize the inclusion of the following types of information which I understand is specifically protected by federal/state statues: (Please initial each one you are authorizing)

_____HIV/AIDs Information _____Alcohol/Drug Treatment _____Mental Health

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance thereon. I will forward any such written request to revoke consent to the practice office. This consent is valid for three (3) months or until ____/_____/_____. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I can inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the receiving party.

_____ _____
Patient Signature Date of Signature

_____ _____
Witness Signature of Responsibly Party & Relationship