Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

Authorization for Release of Medical Records

Patient Name _____ DOB _____
Last First Middle

Street Address _____ City _____ State _____ Zip _____

Records Release Requested From:

Name _____ Phone _____ Fax _____
Street Address _____ City _____ State _____ Zip _____

Records Release To:

1.) Name _____ Phone _____ Fax _____
Street Address _____ City _____ State _____ Zip _____

2.) Name _____ Phone _____ Fax _____
Street Address _____ City _____ State _____ Zip _____

3.) Name _____ Phone _____ Fax _____
Street Address _____ City _____ State _____ Zip _____

Type or extent of information to be released or received (check all applicable boxes):

□ Medical history, examination reports
□ Operative reports
□ Tests or treatments
□ X-ray, CT or MRI reports
□ Current medications
□ Other _____
_____
_____

Purpose of or Need for Release: _____
_____

This authorization will remain in effect for ninety (90) days per Texas State law. This authorization will be effective for medical records generated to the date of signature.

_____ _____ _____
Signature of Patient/Representative Printed Name of Representative and Relationship to Patient Date

Patient is: □ Minor □ Incompetent □ Deceased

Legal Authority: □ Patient or legal guardian □ Next of kin of deceased