COLORADO WEST OTOLARYNGOLOGISTS, P.C.
425 PATTERSON, SUITE 503
GRAND JUNCTION, CO 81506
970-245-2400
970-242-9092 FAX

TO:	PATIENT IDENTIFICATION:
______________________________	______________________________
Name	Name
______________________________	______________________________
Address	Social Security #
______________________________	______________________________
City/State/Zip	Birth Date

GENERAL AUTHORIZATION: I hereby request that my medical records be released to Colorado West Otolaryngologists, P.C., 425 Patterson, Suite 503, Grand Junction, CO 81506. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed.

SPECIFIC AUTHORIZATION: (   ) Please initial. Specifically authorize the release of the following information.

- ❑ Alcohol and/or Drug Abuse, if any
- ❑ HIV/AIDS Status, if any
- ❑ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

- ❑ Copies of hospital History & Physical, Discharge Summary, Operative Reports
- ❑ Copies of imaging studies
- ❑ Copies of office visits
- ❑ Copies of audiograms
- ❑ Copy of complete chart
- ❑ Other
  (specify): ____

This authorization ends: □ on __________________(no longer than 1 year from date signed)
□ When the following event occurs______________________________

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. A copy of this authorization may be utilized with the same effectiveness as an original.

______________________________	______________________________
Signature of Patient or Parent/Legally Authorized Person	Printed name of person authorized to sign for patient
______________________________	______________________________
Date	How authorized