CAPE ENT
Allergy · Audiology · Aesthetics
Facial Plastic Surgery · Dermatology

Authorization to Release Information

Date: _____

Patient Name: _____

DOB: _____

I, _____ , authorize Cape ENT to release the following information regarding:

☐ History and Physical
☐ Consultation Reports
☐ Operative Report
☐ Radiology Report
☐ Test Results
☐ Laboratory Report
☐ Discharge Summary
☐ EKG Report Date
☐ Treatment Summary
☐ Other: _____

_____ _____

Signature of Patient, Guardian or Medical Power of Attorney *Date*

****I understand that I may withdraw this consent at any time.****

Withdrawal:

I withdraw consent for _____ effective _____.

Name of Patient *Date*

_____ _____

Signature of Patient, Guardian or Medical Power of Attorney *Date*