



OTOLOGY/NEUROTOLOGY  
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AUDIOLOGY  
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## AUTHORIZATION TO RELEASE RECORDS / INFORMATION

By providing the following information you are authorizing Rocky Mountain Ear Center, PC to provide medical information to anyone listed below. Please include anyone whom you would allow Dr. Kelsall and/or the staff at RMEC to communicate with regarding your medical information. This could include family members (other than a spouse or parent), caregiver, audiologist, speech therapist, school contact, etc.

**\*\*Please note that your information can not be released to contacts that are not listed below.**

### Primary Care Physician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

### Referring Physician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

### Speech Therapist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

### Audiologist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

### Other \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

Patient:

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

Person authorized to sign for patient:

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_