

**AUTHORIZATION TO REQUEST THE RELEASE OF MEDICAL
RECORDS/INFORMATION**

To: _____
(Doctor or Facility)

Address: _____

Phone: _____ Fax _____

I hereby authorize and request you to release the following information:

_____ Medical Chart Records

_____ Cochlear Implant Records

_____ Hearing Aid Records

_____ MRI, CT or X-ray Films/Disc

To: DAVID C. KELSALL, MD
ROCKY MOUNTAIN EAR CENTER, PC
MEDICAL PLAZA 1
601 E. HAMPDEN AVE., STE 530
ENGLEWOOD, CO 80113
303-783-9220 PHONE
303-806-6292 FAX

Patient Name: _____

or

Person authorized to sign for patient:

(Please print)

(Please print)

Signature

Signature

Patient date of birth

Relationship to the patient

Date: _____