Rocky Mountain EAR CENTER, P.C.

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 _____ Date _____

Print Name _____ Date of Birth _____

Person Authorized To Sign For Patient:

Signature _____ Date _____

Print Name _____ Relationship to Patient _____