Rocky Mountain EAR CENTER, P.C.

Authorization to Request the Release of Medical Records / Information

Physician _____

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/Discs

To:

David C. Kelsall, MD
Rocky Mountain Ear Center, PC
Medical Plaza 1
601 E. Hampden Ave., STE 530
Englewood, CO 80113
Phone: 303.783.9220
Fax: 303.806.6292

Patient:

Signature _____ Date _____

Print Name _____ Date of Birth _____

Person Authorized To Sign For Patient:

Signature _____ Date _____

Print Name _____ Relationship to Patient _____