CANYON SKY ENT
Comprehensive Ear Nose & Throat Care

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Maulik B. Shah, MD
Board Certified Otolaryngologist

Kristina Garza, Au.D., CCC-A
Doctor of Audiology

Medical Records Release

Patient Name: _____
(Last) (First) (Middle)

Street Address: _____ Date of Birth: _____

City, State, Zip: _____Telephone: _____

Email Address: _____

Release Information From:		**Release Information To:**	
(Name of facility, person, company)	(Relationship)	(Name of facility, person, company)	(Relationship)
(Street address or PO Box)	(Phone Number)	(Street address or PO Box)	(Phone Number)
(City, State, Zip)	(Fax Number)	(City, State, Zip)	(Fax Number)

Purpose of Release (check reason): ☐ Request of Individual/Personal ☐ Insurance ☐ Continued patient care ☐ Legal
☐ Other: _____

Medical Records Release: ****A $10.00 charge will be collected prior to release of records****

☐ All medical records from _____ to _____.

☐ All medical records ☐ EXCEPT _____
(List conditions, treatments or type of medical records)

Delivery Method (only select one): ☐ US Mail ☐ Pick-up ☐ Fax: _____
(Fax number)

☐ Other: _____ **Date of upcoming appointment:** _____

I understand that if the person or entity that receives this information is not a health plan or a health care provider covered by federal privacy regulation, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.
*I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell, anemia, psychological or psychiatric impairments, sexually transmitted diseases, HIV/AIDS and/or Aids related complex (ARC). This authorization will expire in 365 days unless otherwise noted.

Signature: _____ **Date:** _____

Print Name: _____
☐ Patient or Authorized representative (must provide POA paperwork): ☐ Guardian ☐ Parent ☐ Other: _____

*Please note: The information following the asterisk above applies to minors as well as emancipated minors.