MEDICAL RECORDS RELEASE/REQUEST FORM

Patient Name: ______________________________________ DOB: ____/____/______ Todays Date: ____/____/______

I authorize release of my records from Sinus Solutions, practice of Terrance Kwiatkowski, MD to the party (parties) listed below. I understand that the specific types of information to be released are only those records generated by this office and/or ordered by Dr. Kwiatkowski.

____
NAME

____
ADDRESS

____
CITY, STATE, ZIP

____
NAME

____
ADDRESS

____
CITY, STATE, ZIP

I hereby authorize the release of the following:

- ☐ All Medical Records
- ☐ CT Scans / X-rays / MRI
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Billing Information
- ☐ Other ____

This authorization for disclosure of information is valid for (1) year from the date signed and can be revoked at any time by written notification of a signor.

____   ______/______/______
Signature of Patient or Authorized Person to Consent   Date

______/______/______
SSN

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