Bluegrass Ear, Nose & Throat

Pediatric and Adult Specialties Care ALBERT SPEACH, M.D. KAREN E. KALLIO, Au.D., CCC/A

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PATIENT	
NAME:	
DOB:	SSN:
Address:	
Phone:	
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I hereby authorize the release of medical records following:	of the aforementioned patient to include the
Complete Medical Records	All Medical Records - specific dates
Lab Results/Reports	Surgical Record/Operative Notes
Hospital Admit/ H&P	Hospital Discharge Summary
Other:	
Please release the requested information to/from	·
(Signature of patient/legal guardian)	(Date)
(Signature of witness)	

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