

T E N T



TUCSON
EAR, NOSE & THROAT

East Office
6567 E. Carondelet Dr.
Suite 515
Tucson, AZ 85710
(520) 296-8500

Northwest Office
6320 N. La Cholla Blvd., Suite 300
Audiology - Suite 350
Tucson, AZ 85741
(520) 575-1272

Central Phone: (520) 296-8500 www.tucsonent.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM TUCSON ENT ASSOCIATES, PC

PATIENT INFORMATION(PLEASE PRINT):

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

**TUCSON ENT ASSOCIATES, PC
6567 E CARONDELET, STE 515
TUCSON, AZ 85710
ATTENTION: SHAUNA
(520) 296-2454, EXT 1130
FAX NUMBER: (520) 495-7508**

TO:

PATIENT/LEGAL GUARDIAN OR PHYSICIAN

(Please circle only one)

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ Phone: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic test results.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient or Legal Guardian: _____ Date: _____

The PHI contained in this letter is HIGHLY CONFIDENTIAL.
Any other use is a violation of HIPAA and will be reported as such.

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|--------------|--|---|---|--|
| Physicians | John B. Chastain, M.D.
Robert B. Cravens, Jr., M.D. | Robert L. Dean, M.D.
David Hu, M.D. | William R. LaMear, M.D.
David A. Parry, M.D. | Keith C. Soderberg, M.D.
Elias D. Stratigouleas, M.D. |
| Audiologists | Sarah Laszok, AuD.
Stephanie M. Navarrete, AuD. | Alisha Severson, MS
Abel Smith, AuD. | | |