Release of Information Authorization

Patient Name: _____ DOB: _____

I, _____ , authorize _____ to release the following information:

☐ Information specifically pertaining to: _____

_____

☐ Complete Record

To: _____

ENT Associates of East Texas

Attn: _____

323 E. Hawkins Pkwy., Suite F, Longview, TX 75605, Fax# 903-230-8825

Signed: _____

Date: _____

I understand that you will provide this information within 30 days from the receipt of this request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.