ENT
ASSOCIATES OF EAST TEXAS

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: _____

1136 E Grande Blvd., Tyler, TX 75703, Fax # 903-595-3304

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.