MILE HIGH
OTOLARYNGOLOGY

Sarmad Sabour, M.D.
Megan Raffle, Au.D.

RECORD RELEASE

Name: _____ Date of Birth: _____

Phone: _____ SS#: _____

Release To: _____

_____

_____

_____

Release From: _____

_____

_____

_____

I request and authorize the release of information to the organization, agency or individual named above. I understand that the information to be released may include the following condition(s).

1. Drug abuse/Alcohol abuse (Federal Regulation 42 C.F.R., Part 2).
2. Psychological or psychiatric conditions.
3. A test for the presence of antibodies (HIV)/virus that causes AIDS.
4. An AIDS diagnosis and/or an AIDS-related condition.
5. Any third-party source (e.g., hospital, specialist, laboratory).

INFORMATION REQUIRED *(Please select all items you authorize to be released):*

☐ Doctors Notes ☐ X-Ray Reports ☐ Path Reports ☐ Drug/Alchohol Abuse ☐ History & Physical ☐ Lab Reports

☐ Third-Party Record ☐ Diagnostic Stud ☐ AIDS/HIV info ☐ Psych Evals ☐ Other

Treatment Dates: _____ Purpose of Release: _____

_____ _____

Signature of Patient Date

_____ _____

Witness Signature of Legal Guardian/Executor

Fax: (303) 487-6932