The Center for **ENT**
Otolaryngology – Head & Neck Surgery

Sam C. Weber, MD, FACS
Ron L. Moses, MD, FACS
Richard T. Hung, MD, FACS
Eric S. Powitzky, MD, FACS
Brett M. Cordes, MD, FACS
Kristin K. Marcum, MD
S. Ross Patton, MD

DATE: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

From: The Center for ENT

Sam C. Weber, MD/Ron L. Moses, MD
Richard T. Hung, MD/Eric S. Powitzky, MD
Brett M. Cordes, MD/Kristin K. Marcum, MD
S. Ross Patton, MD
6624 Fannin, Suite 1480
Houston, Texas 77030

I hereby authorize the release for all my medical records and test results, including HIV test results, in your possession regarding my illness and/or treatment.

To: _____

_____

_____

I release you, your physicians and employees from liability for following this authorization and request. **Authorization is valid for 90-days from date of signature.**

_____ _____
Patient Name (Please Print) **Date of Birth**

_____ _____
Patient or Legal Guardian Signature **Witness Signature**

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