LAKESHORE
EAR • NOSE • THROAT • SINUS • ALLERGY • FACIAL PLASTIC SURGERY

STEPHEN KRZEMINSKI, D.O., FAOCO ***AOCOO-HNS Board Certified*** ***IAC Accredited ENT CT Facility***
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize: Dr. Stephen Krzeminski, D.O.

To release to Dr. _____
AT _____
Phone _____
Fax _____

_____ _____
Patient Name Date of Birth

The information released is to include:
_____History & Physical _____Progress Notes _____Operative Reports
_____X-Rays _____EKG Reports _____Lab Reports
_____Office Notes _____Other_____

The information listed is to be released for the following purpose only. Any other use is forbidden.

_____ Personal _____ Legal _____Continued Care
This authorization covers my medical information
From (date) _____ To (date) _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken on it (e.g. probation, parole, etc) and that in any event this authorization EXPIRES AUTOMATICALLY AS DESCRIBED BELOW. THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE OF MY SIGNATURE. Pursuant to the Texas Administrative Code (Title 22: Part 9: Chapter 165) I understand this records request will be fulfilled within 15 business days and after the fee of $25 has been paid or a written statement of denial will be provided to me in accordance with the Texas Administrative Code.

I agree that a photocopy of this authorization may be considered valid_____Yes_____No
Information released by me will be____Picked up by individual_____Mailed_____Faxed ____ E-mailed

_____ _____
Signature of Patient or Legal Rep Date

_____ _____
Relationship to Patient Date

_____ _____
Witness Signature Date