LAKESHORE

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

STEPHEN KRZEMINSKI, D.O., FAOCO *AOCOO-HNS Board Certified* *IAC Accredited ENT CT Facility*

Jennifer Winkle, MS., CCC-A • Clinical Audiologist Jessica Tryon, MSN, FNP-C • Nurse Practitioner

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www.lakeshoreearnosethroat.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize Dr. ______________________________________

AT ______________________________________

Phone __________________________________

Fax______________________________________

To release to: Dr. Stephen Krzeminski, D.O.
Lakeshore, ENT (817) 573-6673 Phone
1305 Paluxy Rd, Suite A (817) 573-9783 Fax
Granbury, Texas 76048

___________________________________ __________________

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.

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

____________________________ ______________________

Signature of Patient or Legal Rep Date

_______________________________ ______________________

Relationship to Patient Date

_______________________________ ______________________

Witness Signature Date