Central Missouri Ear, Nose Throat, Sinus & Allergy, PC

Robert J. McDonald, Jr., MD
Yolanda Williams, RN, CS, FNP
3527 West Truman Blvd., #200
Jefferson City, MO 65109
Phone: 573-659-5570
Fax: 573-659-5577

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE NOTE: A COPY FEE MAY BE CHARGED
AND MUST BE PAID PRIOR TO THE RELEASE OF ANY INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other _____

I hereby release the physician and employees from any and all liability, claims for causes of action for providing the medical information requested.

Signature: _____ Date Signed: _____

Relation to Patient: _____

THIS AUTHORIZATION EXPIRES SIX (6) MONTHS AFTER IT IS SIGNED UNLESS REVOKED EARLIER IN WRITING