THOMAS IRWIN, M.D.
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·Otolaryngology/Head & Neck Surgery
·Facial Plastic & Reconstructive Surgery
·Specializing in Balloon Sinus Dilation & Rhinoplasty

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Patient Name:	**Date of Request:**
Date of Birth:	**SS#:**
Mailing Address:	

I authorize:
Name: _____
Mailing Address:_____
Telephone Number: _____

♦ **TO RELEASE Information TO** OR ♦ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name:_____
Mailing Address:_____
City, State, ZipCode:_____Phone:_____

The Purpose of this Authorization is indicated in the box(es) below.
(Circle the reason(s) that apply.)

oFurther Medical Care
oCreating health information for disclosure to a third-party
oPersonal
oChanging Physicians
oLegal Investigation or Action
oResearch related treatment

I authorize the release of the following protected health information.
(Check the box information you want released or you want to obtain.)

oEntire Record
oReports
oPrescriptions
oLaboratory Reports
oMedical History
oSurgical Reports
oImmunizations
oRadiology Reports
oExamination
oTreatment or Tests
oHospital Records including Reports
oMR/DD Records

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:
oAlcohol or Drug Abuse oVocational Rehab oHIV (AIDS) or other STD's oGenetics oMental Health

This authorization shall expire on _____ (date or event)
and is needed for the period beginning _____and ending _____.
I understand that this authorization will expire six (6) months from request date**.**

_____
Signature of Individual or Personal Representative Authorized by Law

_____
Signature of Witness (If signed with an "X" or mark)