

**COLORADO WEST OTOLARYNGOLOGISTS, P.C.**  
**425 PATTERSON, SUITE 503**  
**GRAND JUNCTION, CO 81506**  
**970-245-2400**  
**970-242-9092 FAX**

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PATIENT IDENTIFICATION:

RELEASE TO:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Address

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Colorado West Otolaryngologists, P.C. to release my medical records to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Colorado West Otolaryngologists, P.C, my physician and all CWO personnel from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: (     ) Please initial. Specifically authorize the release of the following information.

- Alcohol and/or Drug Abuse, if any
- HIV/AIDS Status, if any
- Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

- Copies of hospital History & Physical, Discharge Summary, Operative Reports
- Copies of imaging studies
- Copies of office visits
- Copies of audiograms
- Copy of complete chart
- Other  
(specify): \_\_\_\_\_

A copy of this authorization may be utilized with the same effectiveness as an original.

\_\_\_\_\_  
Signature of Patient or Parent/Legally  
Authorized Person

\_\_\_\_\_  
Printed name of person authorized to  
sign for patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
How authorized

Records released by: \_\_\_\_\_ Date: \_\_\_\_\_