RALPH METSON, M.D., F.A.C.S
OTOLARYNGOLOGY | NASAL & SINUS SURGERY | FACIAL PLASTIC SURGERY
ZERO EMERSON PLACE, SUITE 2D
BOSTON, MASSACHUSETTS 02114
TEL: 617-227-4366 |FAX: 617-227-4482

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly.
Your medical records cannot be released until this form is completed, signed by the patient or legal guardian

STEP 1: Information about patient: **PLEASE PRINT!!**

Patient Name: _____________________ _______________ Date of Birth: _________ SS Number: _____________
Last First

Address: ____ ____________________ _______ __________
Street City State Zip

Telephone number: ____________________ _____________________
Home Work

STEP 2 Who has the record now? **PLEASE PRINT!!**

I hereby authorize ____ M.D. Phone: _____________________

Address: ____________________________________ ______________________ _______ ______
Street City State Zip

STEP 3 To whom do you wish to release your records? **PLEASE PRINT!!**

To release the following information, please specify:

ALL RECORDS or Date of Treatment: _____________to_______________ Other:________________

Send records to: __________________________________M.D. Phone: ______________ Fax: ________________

Address: ____ ____________________ ____________ ___________
Street City State Zip

STEP 4 SIGNATURE **Date: _________________**

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.
Additional authorization for redisclosure beyond 90 days is required.

__________________________________ or ___________________________ _____________________________
Patient's Signature Parent/Guardian's Signature Witness Signature

STEP 5 Release for SENSITIVE INFORMATION: **Date: __________________**
I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE:

_________________________________ or _____________________________ ______________________________
Patient's Signature Parent/Guardian's Signature Witness Signature

STEP 6 Release for HIV INFORMATION: **Date: __________________**
IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN ON THE LINE BELOW:

_________________________________ or _______________________________ ____________________________
Patient's Signature Parent/Guardian's Signature Witness Signature

IT MAY TAKE 7-10 DAYS TO PROCESS THIS REQUEST

Office use only: Date chart copied: __________ Copied by whom: _________ (initials) Date released: ____________