



VAIL VALLEY EAR, NOSE & THROAT *Group, P.C.*

R. Casey Strahan, M.D.  
P.O. Box 1366  
Edwards, CO 81632

### Authorization for Release of Medical Records

(There is a \$10 processing fee for each record sent, please enclose a check made out to VVENT, and mail to:  
VVENT, PO Box 1366, Edwards, CO 81632)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Vail Valley Ear, Nose & Throat Group to disclose the following health care information:

- All of my health information maintained by the above named practice, or:
  - Other (specify): \_\_\_\_\_
- 

You may disclose this health information to:  
(please specify person to receive the information and their mailing address)

Me (the patient):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

My doctor:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

This authorization ends in one year or:  on (date) \_\_\_\_\_ or,  
 when the following event occurs: \_\_\_\_\_.

I understand that I may revoke this authorization at any time. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, send a written request to VVENT, P.O. Box 1366, Edwards, CO 81632.

\_\_\_\_\_  
Signature of patient or legally authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of patient

\_\_\_\_\_  
Relationship (parent or legal guardian)