RECORDS RELEASE AUTHORIZATION

TO REFERRING/CONSULTING PHYSICIANS:

_____

_____

_____

PATIENT NAME: _____

DOB: _____

ADDRESS: _____

_____

_____

I hereby authorize and request permission for release of a complete copy of my medical records to Gary D. Paige, MD, PhD. I specifically authorize the releasing of information pertaining to any head or body trauma, antibiotic history, psychiatric history, and drug and/or alcohol abuse, if such is a part of my medical history. This consent may be revoked in writing at any time.

I hereby authorize Gary D. Paige, MD, PhD, to send VNG, Audiogram and/or consultation reports to my primary and consulting physicians as requested. This consent may be revoked in writing at any time.

_____ **Date:** _____

Patient or Authorizing Signature
(and relationship)