



5025 Deepwood Circle
 Corpus Christi, TX. 78415
 Phone: 361-288-2865 Fax: 361-888-9126

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Gulf Coast ENT and Allergy

Address: 5025 Deepwood Circle

City: Corpus Christi State: Texas Zip Code: 78415

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

 Gulf Coast ENT and Allergy is committed to protecting the privacy of your medical and personal information. We will not use or disclose your health information for any other purpose without your permission.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.