

Beaches Ear Nose and Throat, PA

Jeffrey E. Brink, M.D.,F.A.C.S

Stephanie Collins, PA-C

Jeffrey Lezynski, Au.D.

MEDICAL RELEASE FORM

I, _____
authorize _____
to furnish medical information and records concerning _____
_____ to _____
for the purpose of _____.

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited. An additional written consent must be completed for any proposed new use of the information or for its transfer to another person or entity.

I release and hold harmless Jeffrey E. Brink, M.D., and the physician's medical practice, Beaches Ear, Nose and Throat, P.A., members and employees, for all liability, including for negligence that may arise from complying with this authorization. I understand that the medical record maintained by Jeffrey E. Brink, M.D., may contain medical and administrative information from other health care providers.

Patient Name _____ DOB _____

Address _____

Signature _____ Date _____

Relationship to Patient _____

Witness Signature _____

Jacksonville Beach: TEL (904) 247-4070 or FAX (904) 247-4131

Fernandina Beach: TEL (904) 321-4341 or FAX (904) 321-2159