Medical Records/Medical Information Authorization

I _____, give permission to Great Lakes Ear, Nose & Throat Specialists to discuss my condition and/or obtain my medical records with the following people:

1. _____

2. _____

3. _____

A copy of this form will be kept in your medical record and will stand as our authorization to release information regarding your medical condition.

For those requesting a copy of your medical records, identification must be provided at time of pick up. A copy of the source of identification will be scanned and kept on file.

Thank you,

The Providers at Great Lakes Ear, Nose & Throat Specialists