Robert W. Poe, MD
Brunswick Sinus
900 N. Howe St.
Southport, NC 28461
(910) 457-0734

Consent to Release Records

Patient's full name: _____

Patient's date of birth: _____

I Hereby Authorize Dr. Robert W. Poe to send requested information to:

Name: _____

Address: _____

_____

Fax No.: _____

This information shall include: _____

I understand that I may revoke this authorization at any time by notifying Brunswick Sinus in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Brunswick Sinus prior to receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, or eligibility benefits.

_____ Date: _____
(Signature of Patient or responsible party, full name)

_____ Date: _____
(Witness by Employee of Brunswick Ear, Nose, and Throat)

Information Sent: _____
Date Information Sent: _____
Sent by: _____