

REFERRING AND PRIMARY PHYSICIAN INFORMATION

In order to release information back to the physician who requested your consultation and/or your primary physician, Port Huron E.N.T.,P.C. needs the following information and authorization.

Physician requesting consultation

Physician Name: _____ **D.O. M.D. D.D.S.**
(Circle One)

Address & Tel. # *(If known)*: _____

Primary Care Physician (Family Physician)

Physician Name: _____ **D.O. M.D. D.D.S.**
(Circle One)

Address & Tel. # *(If known)*: _____

I, *(Print name)* _____ authorize
Port Huron E.N.T., P.C. to release medical information contained in the medical chart of
(Print patient name) _____ to the
physician(s) listed above.

Patient Signature (Parent Legal Guardian in case of Minor:

_____ ***Date:*** _____