



**ON SLOW**  
EAR NOSE & THROAT

affiliated with  **Onslow**  
MEMORIAL HOSPITAL

**Onslow Ear, Nose, & Throat**

**55 Office Park Drive**

**Jacksonville, NC 28546**

**Phone: 910-219-3377 Fax: 910-577-4983**

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize and request Onslow Ear, Nose, & Throat to release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This authorization and request applies to:

Healthcare information related to the following treatment, condition, or dates:

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_