



**Cumberland  
Otolaryngology  
Consultants, PSC**

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**OUTGOING RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_

I authorize Cumberland Otolaryngology Consultants, PSC to release to:

\_\_\_\_\_  
(name of party to receive information)

\_\_\_\_\_  
(address of party to receive information)

Reason for release:

\_\_\_\_\_

Release only these records:

- |  | Initials |
|--|----------|
| 1. Only records generated by this facility (not including records from other sources...    | _____    |
| 2. Only portions of records at this facility (dates of treatment, etc. specify below)..... | _____    |
| 3. All medical records at this facility.....   | _____    |
| 4. Other (please specify).....   | _____    |

I **DO NOT** want records pertaining to the following released:

- \_\_\_\_\_ Substance abuse, if any  
 \_\_\_\_\_ Psychological or psychiatric conditions, if any  
 \_\_\_\_\_ AIDS/HIV, if any

Other (Please specify) \_\_\_\_\_

I understand that I may revoke this consent to release information at any time. I also understand that my release shall not constitute a breach of my right to confidentiality. This authorization expires 60 days from the date below, and it covers only treatment prior to that date. I understand that the information released cannot be redisclosed by person(s), institution(s) named above unless I specifically authorize such a release in writing.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

\_\_\_\_\_  
(Patient or representative signature. Signature by mark must be witnessed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Relationship to patient)

Authorization must be signed by the patient. If the patient is under 18 years of age or is not legally competent or is unable to sign, the parent or designated legal representative must provide authorization.

Cumberland Otolaryngology Consultants, PSC personnel signature \_\_\_\_\_

Date: \_\_\_\_\_