Newburyport Medical Center
1 Wallace Bashaw Jr. Way, Suite 3002
Newburyport, MA 01950
P: 978.997.1550
F: 978.688.8292

200 Sutton Street, Suite 100
North Andover, MA 01845
P: 978.685.2900

Merrimack Medical Center
62 Brown Street, Suite 301
Haverhill, MA 01830
P: 978.521.0300

Daryl Colden, MD, FACS
Board Certified
Otolaryngology – Head & Neck Surgery
Facial Plastic & Reconstructive Surgery
Fellowship Trained
Advanced Nasal & Facial Plastic Surgery
Fellow
American Academy of Otolaryngic Allergy
Clinical Instructor in Otology & Laryngology
Harvard Medical School
Assistant Surgeon in Otolaryngology
Massachusetts Eye & Ear Infirmary
Assistant Clinical Professor
Otolaryngology Head & Neck Surgery
Tufts Medical School

Peter Seymour, MD
Board Certified
Otolaryngology – Head & Neck Surgery
Fellowship Trained
Otologic Medicine & Surgery
(Ear & Balance Disorders)
Associate
American Academy of Otolaryngic Allergy
Assistant Surgeon in Otolaryngology
Massachusetts Eye & Ear Infirmary
Assistant Clinical Professor
Otolaryngology – Head & Neck Surgery
Tufts Medical School

Elizabeth Mahoney Davis, MD, FACS
Board Certified
Otolaryngology – Head & Neck Surgery
Fellow
American Academy of Otolaryngic Allergy
Assistant Professor
Otolaryngology – Head & Neck Surgery
Boston University School of Medicine

Renee Llorente, MA CCC-A
Sarah Wellwood, AuD CCC-A
Pediatric & Adult Audiology
Hearing Aid Evaluation
Aural Rehabilitation

Donna Cardarelli
Office Manager

Hospital Affiliations
Anna Jaques Hospital
Merrimack Valley Hospital
Holy Family Hospital

Surgical Center Affiliations
Andover Surgical Center
Stratham Surgical Center

Academic Affiliations
Massachusetts Eye & Ear Infirmary
Tufts Medical Center
Boston University School of Medicine

www.ColdenSeymourENT.com

COLDEN SEYMOUR

EAR NOSE THROAT & ALLERGY
Adult & Pediatric Care / Hearing & Balance Center
Sinus & Sleep Specialists / Facial Plastic Surgery

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient Name (Print):_____ Chart Number:_____

Date of Birth:_____ AKA (other names):_____

I am the ___PATIENT ___GUARDIAN___CONSERVATOR___DESIGNEE and hereby authorize_____, located at:

_____

to disclose medical information for the above named.

Sent to: (Name of person, organization, or agency and address)

_____

_____Purpose of Disclosure:_____

Dates of Service to Release:_____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care names of all health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease (STD's), including AIDS information.

Exclusions (Please initial:): Drug/Alcohol_____, Mental Health/Psychiatric____, STD's_____
HIV/AIDS_____, Hepatitis_____

This authorization is valid for one year or until_____, whichever comes first.

Patient signature: _____ Date:_____

Print name here: _____

Signature of Parent/Guardian/Conservator/Designee's (If applicable):

_____

Relationship: _____ Date: _____

A photocopy of this release is as valid as the original.

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.

(*There will be a processing fee to release medical records)*