EAR NOSE & THROAT CLINIC

Otolaryngology - Head & Neck Surgery
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MEDICAL RECORDS RELEASE

Patients Name: _____ Birthdate: _____
Phone Number: _____
Address: _____ Apt. Number: _____
City: _____ State/Zip: _____

Records Request From:
Name: _____ Phone Number: _____
Company Name: _____ Fax Number: _____
Address: _____ Suite Number: _____
City: _____ State/Zip: _____

Send Records To:
Name: _____ Phone Number: _____
Company Name: _____ Fax Number: _____
Address: _____ Suite Number: _____
City: _____ State/Zip: _____

How would you like to obtain these records? Please check one.

- ☐ Mail
- ☐ Fax
- ☐ Pick-up (with photo identification)

Please allow us 7 - 10 business days to copy your medical records
Tell us what medical records you would like sent.

- ☐ Complete Medical Records
- ☐ Lab or Pathological Reports
- ☐ Audiometric Studies
- ☐ Medications
- ☐ Other: _____
- ☐ X-Ray Reports
- ☐ Operative Notes
- ☐ Chart Notes
- ☐ Allergy Records

Authorization for Release of Medical Data

This authorization will expire 1 year from signature date below.

Signature: _____ Date: _____
Relationship: _____

FOR OFFICE USE ONLY

Staff Signature: _____ Date: _____
Print Name: _____