FLORIDA ENT ADULT & PEDIATRIC, PA

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OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

REQUEST FOR RELEASE OF PATIENT RECORDS

Date: _____

Patient Name_____ DOB_____

Records Requested □X-ray □Labs □Op Report □Pathology □Other _____

Reason for Request_____

I hereby authorize and request the release of my medical records in your possession concerning my illness and/or treatment

SEND RECORDS TO:	**BE RELEASED FROM:**
_____	_____
NAME	NAME
_____	_____
ADDRESS	ADDRESS
_____	_____
CITY	CITY
_____/_____	_____/_____
PHONE FAX	PHONE FAX

Signed _____ Date _____
Patient or guardian

Witness_____ Date_____

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Office Use Only

Physician Approval_____

Date_____ Employee initials_____

Please remit payment in the amount of $_____ ($1.00 per page up to 25 pages and .25 cents for each additional page) to Florida ENT.