

Otolaryngology
Head & Neck Surgery

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Medical Records Release/Request From
(Processing will require 5 business days from the date of this request)

Patient Name: _____

Date of Birth: _____ Phone number: _____

I am requesting that my records **FROM** The Ear Nose and Throat Center
be released to (send):

Name: _____

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I am requesting that my records be released **TO** The Ear Nose and
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Name: _____

Address: _____

Phone: _____

Fax: _____

Information requested:

Authorization expiration: _____

X _____ Date _____
Signature of patient/guardian