LAKESIDE ALLERGY, EAR, NOSE & THROAT

**Specialists in Otolaryngology/Head & Neck Surgery**

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**REQUEST FOR RELEASE OF MEDICAL RECORDS**

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

 (Please Print)

Name of Parent/Guardian if Minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE RECORDS FROM:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Facility Name)

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 (Address)

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 (City, State, Zip Code)

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 (Phone) (Fax)

**SEND RECORDS TO:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Facility Name)

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 (Address)

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 (City, State, Zip Code)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Phone) (Fax)

\_\_\_\_\_\_\_\_\_Please release all medical records \_\_\_\_\_\_\_\_\_Please release only the following information

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Signature of Patient/Parent or Guardian Date