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)

_____
(Address)

_____
(City, State, Zip Code)

_____
(phone) (fax)

SEND RECORDS TO: _____
(Facility Name)

_____
(Address)

_____
(City, State, Zip Code)

_____
(phone) (fax)

_____ Please release all medical records.

_____ Please release only the following information.

_____

_____

_____ _____
Signature of Patient/Parent or Guardian Date