

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

