EAR, NOSE, THROAT,
& ALLERGY SPECIALISTS

MEDICAL RECORDS RELEASE

PATIENT NAME:_____

DATE OF BIRTH:_____/_____/_____

DATE OF SERVICE REQUESTING:_____/_____/_____

INFO REQUESTING:_____

_____

SEND TO: EAR, NOSE, & THROAT SPECIALIST
215 RIVERSTONE DRIVE
CANTON, GA 30114

REQUESTING FROM: _____
_____
_____
_____

PLEASE RELEASE MEDICAL RECORDS ON THE PATIENT MENTIONED ABOVE VIA:

_____FAX _____USPS

_____ _____

PATIENT OR GUARDIAN'S SIGNATURE DATE

_____ _____

WITNESS DATE