

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please print):

Name: _____ DOB: _____

Social Security No: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

RELEASE OF MEDICAL RECORDS FROM:

Physician: _____

Address: _____

FAX/Phone: _____

**TO: East Alabama Ear, Nose, and Throat, P.C.
1965 1st Avenue,
Opelika, Alabama 36801**

(334) 705-0378 FAX

(334) 705-0012

Please release a copy of all my medical records, including, but not limited to, office notes, operative notes, laboratory results, x-ray reports, audio reports, audio-verbal notes (AVT), etc. unless otherwise listed : _____

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____
Parent or guardian (please circle)