Light E.N.T.

ENT and Allergy Associates of Florida
Caring For Our Patients Since 1963
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Medical Records Release Form

Date:_____ Patient Name:_____

Date of Birth: _____ Last 4 Digits SS#:_____

I hereby request and give my permission to release my medical records to:

Name:_____

Address: _____

City: _____ State:_____ Zip:_____

Phone #:_____ Fax#:_____

- All Medical Records
- Audio Testing
- Test Result (type of Test) _____
- Other: _____

Comments:_____

_____

Method of Release Preferred (circle) Mail Fax Pick-Up

Patient Signature:_____Date:_____

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