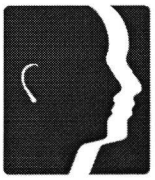

ENT and Allergy Associates of Florida

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Medical Records Release Form

Patient Name: _____ **Date of Birth:** _____

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

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Fax #:** _____

All Medical Records

Test Results (Type of Test) _____

Other _____

Comments: _____

_____

Preferred Method of Release: Mail Fax Pick-Up

Patient Signature: _____ **Date:** _____

Internal Use Only:
Pt Account Number: _____