EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

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Patient Medical Records Release

I AUTHORIZE EASTERN SHORE ENT & ALLERGY ASSOCIATES, P.A. TO RELEASE A COPY OF MEDICAL RECORDS FOR THE PATIENT NAMED BELOW:

Patient Name (please print) **Date of Birth**

PLEASE SEND THE RECORDS TO: _____

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Patient Signature **Date**

Signature of Legal Guardian if Patient is a Minor **Date**

Please include the following:

_____ Admission Note
_____ Discharge Summary
_____Operative Report
_____ Progress Notes
_____ Consultation Rpt
_____ Other

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