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Adult and Pediatric ENT

Request for Release of Medical Records

Date: _____

I request that my medical records be released

From: _____
(Name)

(Address)

(Address)

(City, State, Zip Code)

To: _____
(Name)

(Address)

(Address)

(City, State, Zip)

Patient's Name: _____

Patient's Signature: _____

Patient's Date of Birth: _____