COASTAL
EAR • NOSE • THROAT
ALLERGY
HEARING CENTER

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## MEDICAL RECORDS RELEASE

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name (Print) Birth Date

Address

City State Zip

SSN Printed Name of person signing

I hereby request that my medical records be released from:

Phone Fax

Records being requested: _____ Dates of Service _____ to _____

**Release To:**

Coastal Ear, Nose and Throat
322 Commercial Drive, Ste. 2 Savannah, GA 31406 | 200 Blue Moon Crossing, Ste. 103, Pooler, GA 31322
912.355.2335 | 912.450.2336
Fax: 770.217.3339

**Signature** **Date**