COASTAL
EAR • NOSE • THROAT
ALLERGY
HEARING CENTER

David S. Oliver, MD, FACS | Ian K. McLeod, MD, FACS | Dustin C. Staples, PA-C
Karla McKenzie, MCD, CCC-A

MEDICAL RECORD 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

Social Security Number Printed Name of Person Signing

I hereby request that my medical records be released from:

Coastal Ear, Nose & 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

Records being requested: _____ Dates of Service _____ to _____

Release to:

Name

Address

City State Zip

Phone Fax

Signature **Date**