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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

322 Commercial Drive, Ste. 2 Savannah, GA 31406 | 200 Blue Moon Crossing, Ste. 103, Pooler, GA 31322

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www.coastal-ent.com