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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.

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Patient Name (Print)

Birth Date

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Address

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City

State

Zip

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SSN

Printed Name of person signing

I hereby request that my medical records be released from:

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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

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**Signature**

**Date**