RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

I, _____,

AUTHORIZE :

Name: _____

Address: _____

T0 RELEASE MY RECORDS TO:

SOUTHERN ENT & SINUS CENTER, P.C.
John A. Jebeles, M.D. ; D. Trent Lowery, M.D.;
1809 Gadsden Hwy.
Birmingham, Alabama 35235
205-838-3755
205-838-3758 (fax)

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

_____
Signature of Patient or Responsible Party

_____
Date