RELEASE OF MEDICAL RECORDS
AND/OR INFORMATION

I, _____, AUTHORIZE

SOUTHERN ENT & SINUS CENTER, PC, TO RELEASE MY RECORDS TO THE FOLLOWING (where records are to be sent)

Name: _____

Address: _____

_____

_____

Phone #: _____

Fax #: _____

PATIENT: _____

PATIENT'S DATE OF BIRTH: _____

_____

Signature of Patient or Responsible Party

_____

Date