RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

I, _____, AUTHORIZE:

Name: _____

Fax number:_____

TO RELEASE MY RECORDS TO:
SOUTHERN ENT & SINUS CENTER, P.C.
D. Trent Lowery, MD; David Walters, MD; Matthew Fort, MD
1809 Gadsden Highway
Birmingham, AL 35235
205-228-7970 (fax) 205-661-0127

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

_____
Signature of patient or responsible party

_____
Date