Albany ENT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO ALBANY EAR, NOSE AND THROAT

TO: _____

_____

(ADDRESS)

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MEDICAL RECORDS YOU HAVE REGARDING:

NAME: _____DOB:_____

ADDRESS: _____

SIGNATURE: _____DATE: _____

(IF RELATIVE-STATE RELATIONSHIP)_____

WITNESS: _____

PLEASE FORWARD RECORDS TO: ALBANY EAR, NOSE AND THROAT
605 POINTE NORTH BLVD
ALBANY, GA 31721
229-435-7161
229-438-8588 (FAX)