PENTA
pediatric ear nose and throat associates

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Medical Records Release

(Physician's Office Form)

Please complete the following information:

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

I, _____, authorize the release of all medical records, pertaining to the treatment of any ear, nose, and throat condition, for the patient mentioned above. This release will give PENTA permission to obtain medical records from any office that might have protected health information that will help in treating the patient mentioned above regarding any ear, nose, and throat condition.

If there are any records that you would like to restrict an office from sending, please list those records, and what office they would be coming from, below:

_____

_____

_____ _____

Signature of parent or authorized representative Date

Printed name of parent or authorized representative	Witness