THE CENTERS FOR ADVANCED ENT CARE
CHESAPEAKE EAR, NOSE, AND THROAT

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REQUEST FOR MEDICAL RECORDS

To: _____ Date: _____

_____

_____

Phone: _____

Fax: _____

To Whom It May Concern:

I hereby request that the release of my protected health information be released to Chesapeake Ear, Nose & Throat, a division of Centers for Advanced ENT Care, LLC

Fax to: 443-548-2998

Or mail to main office: 23 Crossroads Dr Suite 400 Owings Mills, MD 21117

If your office is in possession of any records from another provider,

_____ I DO wish to have those records released under this authorization.

_____ I DO NOT wish to have those records released under this authorization

I understand that this request is valid for a full year and will expire one year from the date it is signed unless a shorter time is indicated here: _____

_____ _____

Patient's name printed Patient's signature

_____ _____

Patient's date of birth Patient's phone number

Please complete below if the patient is a minor:

_____ _____

Parent or legal guardian name printed Parent or legal guardian signature