



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: 410-876-4495

Or mail to: 410 Malcolm Dr Suite E Westminster, MD 21157

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

23 Crossroads Dr. Suite 400  
 Owings Mills, MD  
 410-356-2626

410 Malcolm Dr. Suite E  
 Westminster, MD  
 410-876-9300

5233 King Ave Suite 112  
 Rosedale, MD  
 410-391-1118

10025 Gov Warfield Pkwy Suite 101  
 Columbia, MD  
 410-356-2679