Lake Breeze
ENT & Allergy

Medical Records Release

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ Phone: _____

Responsible Party Name: _____ Relationship to Patient _____

***Please place a check beside the information you want released:**

__ **Complete Health Record**	__ Laboratory Results
__ Office Notes	__ Hearing Test
__ Radiology Reports (X-Ray, CT, MRI)	__ Allergy Testing
__ Operative Reports	__ Other:

(please specify if other)

I request the above medical records indicated to be released: □by or □to

Lake Breeze ENT & Allergy
149 Plantation Ridge Dr. #190
Mooresville, NC 28117 - 704-658-0916 Fax

This information is to be □obtained by or □released to _____for the purpose of _____.

Release To:

Dr. _____
Address: _____
Phone: _____
Fax: _____
_____

I understand that this authorization will be kept of file for use by Lake Breeze ENT & Allergy and may be revoked in writing at any time. Unless otherwise revoked, this authorization will expire in 12 months.

Responsible Party/Patient Signature: _____Date:_____/_____/_____

The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

For Office Use Only:

_____
Date Records Released
Sent By: FAX MAIL E–MAIL PATIENT PICKUP