

RECORDS RELEASE / REQUEST

Name: _____
(Doctor / Hospital)

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

I hereby authorize the release of my:

- | | |
|--|---|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Radiographic Films |
| <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Radiographic Reports |
| <input type="checkbox"/> Hospital Notes | <input type="checkbox"/> Audiograms |
| <input type="checkbox"/> Other _____ | |

Or copies of such, and request they be transferred:

- To From

ADVANCED EAR, NOSE & THROAT ASSOCIATES, P.C.
50 EAST DUNLAP, SUITE 102
PHOENIX, ARIZONA 85020
PH. (602) 944-3311
FX. (602) 944-1968

Ben E. Leff, M.D.

Deven S. Gujrathi, M.D.

PRINT NAME OF PATIENT DOB

FROM: _____ TO: _____
DATE OF RECORDS

SIGNATURE DATE