REQUEST FOR RELEASE OF RECORDS

I hereby request and authorize that:

NAME OF PHYSICIAN: _____

PHONE NUMBER: _____

FAX NUMBER: _____

ADDRESS: _____

RECORDS NEEDED: _____

Release of medical records in your possession concerning my overall health care, illnesses and treatments administered to me to:

****PLEASE NOTE: FOR RADIOLOGY REQUESTS, WE DO NOT ACCEPT FILMS – PLEASE SEND REPORT ONLY****

Potomac ENT a Division of CAdENT
14000 Crown Ct #201
Woodbridge, VA 22193
Tel. 703-499-8787
Fax # 703-499-8222

NAME: _____

SIGNATURE: _____

ADDRESS: _____

CITY, STATE,ZIP: _____

TODAY'S DATE: _____

DATE OF BIRTH: _____ SS# NUMBER: _____

WITNESS: _____ DATE: _____