EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

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Provider Medical Records Release

I HEREBY AUTHORIZE : _____

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TO RELEASE A COPY OF MEDICAL RECORDS FOR THE PATIENT NAMED BELOW:

_____

Patient Name (please print) **Date of Birth**

PLEASE SEND THE RECORDS TO: **Eastern Shore ENT & Allergy Associates, P.A.**
106 Milford St, Suite 101
Salisbury, MD 21804
(410) 742-1567 (press 5)
info.esenta@gmail.com

_____

Patient Signature **Date**

_____

Signature of Legal Guardian if Patient is a Minor **Date**

Please include the following:

_____ Admission Note
_____ Discharge Summary
_____Operative Report
_____ Progress Notes
_____ Consultation Rpt
_____ Other

Revised June 2019