

## PROVIDER MEDICAL RECORDS RELEASE

I HEREBY AUTHORIZE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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 Street, 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
- Progress Notes
- Discharge
- Summary
- Consultation Report
- Operative Report
- Other

*Revised June 2019*