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Georgetown Medical Building
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913-261-2223, Fax 913-261-2224
Adult and Pediatric ENT

Request for Release of Medical Records

Date:_____

I request that my medical records be released

From: _____
(Name)

_____
(Address)

_____
(Address)

_____
(City, State, Zip Code)

To:_____
(Name)

_____
(Address)

_____
(Address)

_____
(City,State,Zip)

Patient's Name: _____

Patient's Signature:_____

Patient's Date of Birth: _____