MEDICAL RECORDS RELEASE FORM

ATLANTIC ENT LLC
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COCOA BEACH, FLORIDA 32931
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PATIENT NAME: ____

HOME ADDRESS: ____

CITY, STATE & ZIP CODE: ____

PATIENT DATE OF BIRTH: _______________________________________

BEST TIME AND TELEPHONE# FOR US TO CONTACT YOU:

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I HEREBY AUTHORIZE ATLANTIC ENT LLC AND MICHAEL WIDICK, MD TO RELEASE ALL OF MY MEDICAL RECORDS TO:

NAME: ____

FACILITY: ____

ADDRESS: ____

CITY, STATE & ZIP CODE: ______________________________________

CONTACT IF AT FACILITY OR MD OFFICE: __________________________

FAX#: ____

TELEPHONE#: ____

DATE YOU WISH TO PICKUP MEDICAL RECORDS: ____________________

DATE AND SIGNATURE OR PATIENT OR LEGAL GUARDIAN:

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