David Mendelson, D.O., F.A.O.C.O.
Suzanne Rauch, PA-C

ENT Specialists of Arizona, P.C.

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ **DOB:** _____

Patient Address: _____

_____

I hereby authorize and request ENT Specialists of Arizona, P.C. to:

____Release my medical record to:
____Obtain my medical record from:
____Discuss my medical record with:

Name: _____ Fax#_____

Address: _____

_____

Specify type of record:

o Progress Notes	o Allergy Notes
o Labs	o Auditory Reports
o Radiology	o Sleep Study
o Pathology Reports	o Operative Reports
o All	o

This release will expire on_____

Signature of Patient, Parent, or Guardian _____ Date: _____

Witness: _____ Date: _____

1492 S. Mill Ave. •Suite 301 • Tempe, AZ 85281 • (480) 894-5550 • Fax: (480) 894-9469
10238 S. Hampton Ave. • Suite 411 • Mesa, AZ 85209 • (480) 964-4415 • Fax: (480) 964-4582