

**ENT SPECIALISTS OF ARIZONA, P.C.**

*David B. Mendelson, D.O., F.A.O.C.O.*

*Linda S. MacConnell, PA-C, MPAS*

**MEDICAL RECORDS REQUEST AUTHORIZATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

OBTAIN(from other physician)     SELF     SEND TO

I hereby authorize ENT Specialists of Arizona to release/or obtain my records (circle one)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Fax Number (if known): \_\_\_\_\_

Progress Notes

Allergy Notes

Labs

Auditory Reports

Radiology

Sleep Study

Pathology Reports

Op Reports

All

This notice will expire on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date