Quinn
Ear, Nose & Throat

25 Lake Concord Rd.
Concord NC 28025
(704) 782-6673

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name _____

Address _____

Birth Date _____ Social Security No. _____

I hereby authorize and request that my medical records be released:

❑ To Dr. Quinn ❑ From Dr. Quinn

Office Name _____

Address _____

Phone _____ Fax _____

RECORDS REQUESTED

- ❑ All Relevant Records
- ❑ Audiogram
- ❑ Recent Lab Work, X-Rays, Pathology Reports, Other Reports
- ❑ Allergy Skin Test, Rast Test, Allergy Vaccine Contents/Formula
- ❑ Other _____

INSTRUCTIONS

- ❑ Please FAX records to (704) 782-6605 ASAP
- ❑ Urgent - Patient is waiting to be seen by the Doctor
- ❑ Please mail records to 25 Lake Concord Rd., Concord NC 28025

I hereby confirm that I have legal authority to sign this Release form to obtain records

_____ _____
Signature Date

_____ _____