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ATLANTIC Ear, Nose & Throat

963 Town Center Drive
Orange City, FL 32763
Tel (386) 774 - 9880
www.myENTdoctor.com

Release of Atlantic Ear, Nose & Throat Records

Today's Date _____

Patient's Last Name _____ First Name _____

Date of Birth _____ Social Security # _____

I am requesting the following information *(please be specific)* for the patient specified above:

_____

_____

_____

My reason for the request is: _____

_____

Your medical records will be **placed on your patient portal**, unless you request otherwise.

- ❑ I prefer to pick up my records in person from the Orange City office.
- ❑ Please mail my records to me at the following address:

  _____

  _____

- ❑ Please fax my records to the attention of _____

  At this facility / physician's office _____

  Their tel # is _____ Their fax # is _____

I understand it may take up to 30 days to fulfill this request.

_____	_____	_____
Signature	Printed Name	Relationship to Patient

This form can be mailed to 963 Town Center Dr., Orange City, FL 32763 OR faxed to (386) 774 – 2898.