Coastal
Ear, Nose & Throat

Medical Record Release Form

This is a written request for my medical records be sent from Coastal Ear, Nose and Throat to the person or facility listed below. I give my consent to share medical information with the appointed person/facility knowing that it contains private health information and I authorize designated personnel to send it using the patient privacy laws that are required by the State of New Jersey.

Facility or Physician _____
Facility Address _____
Phone #:_____ Fax #:_____

_____ _____
Printed Patient Name Date of Birth

_____ _____
Patient's Signature Date of Request

__complete chart ___labs/radiology reports ___office notes ___other

__ specific date(s) of service Dates:_____

Please list any other specific notes that the patient coordinator may need to help process your request in the lines below:

_____

_____

_____

Disclaimer: Following State Law this office is allowed 30 days to send records from the date of the request but we will try to process it as quickly as possible. We apologize for any inconvenience.

Otolaryngology • Head and Neck Surgery • Board Certified in Pediatric and Adult Care
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