Medical Record Request Form

Please email form to info@chicagoent.com

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I hereby authorize Chicago ENT to release information from the medical record of:

Patient Name: _____

Address: _____

_____

Phone: _____ DOB: _____

To: _____

Address: _____

_____

Phone: _____ Fax: _____

This information will be used for the purpose of:

_____

Only the information specified below may be released:

_____

_____

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent will automatically expire at the earliest date below as specified:

☐ After 90 days ☐ Otherwise expressly stated _____ _____

Patient Signature Date

Note: Medical record requests could take up to 30 days

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