CHESAPEAKE SPECIALTY CARE
CHESAPEAKE ENT ALLERGY AUDIOLOGY

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REQUEST FOR MEDICAL RECORDS

To: _____ Date: _____

_____

_____

Phone: _____

Fax: _____

To Whom It May Concern:

I hereby request that the release of my protected health information be released to Chesapeake Ear, Nose & Throat, a division of Chesapeake Specialty Care.

Fax to: 443-769-1188
Or mail to main office: 10025 Governor Warfield Parkway Suite 101 Columbia, MD 21044

If your office is in possession of any records from another provider,

_____ I DO wish to have those records released under this authorization.
_____ I DO NOT wish to have those records released under this authorization.

I understand that this request is valid for a full year and will expire one year from the date it is signed unless a shorter time is indicated here: _____

_____ _____
Patient's name printed Patient's signature

_____ _____
Patient's date of birth Patient's phone number

Please complete below if the patient is a minor:

_____ _____
Parent or legal guardian name printed Parent or legal guardian signature