



Authorization to Receive Patient Information

Patient Name: _____ Date of Birth: _____

I hereby consent to the disclosure of the specific information listed below, as it concerns the above named patient of Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.

I am authorizing:

Name of Outside Facility/Physician: _____

Mailing Address: _____
Address City State Zip

Telephone #: _____ Fax #: _____

To release the medical records contained in the above named patient’s medical record:

Date(s) of Treatment: From: _____ To: _____

Re: The Diagnosis of: _____

Other: _____

Please forward these records (as specified above) to:

Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.
PO Box 76479
St Petersburg, FL 33734
Telephone: (727) 329-5400
Fax: (727) 329-5401

Please forward these records by the following method of communication:

____ US Postal Mail

____ Fax: 727-329-5401

____ OR – You may visit our website at www.pediatric-ent.com/patient-portal and log into our Patient Portal.

Signature of Legal Representative

Date of Signature

(This signature is valid for one (1) year from the above “Date of Signature.”)

Relationship to Patient

Phone number where you may be reached

PLEASE NOTE:

Only test results, the office visit notes and/or surgery notes of the physicians/physician extenders of Pediatric Otolaryngology Head & Neck Surgery Associates, PA will be copied and forwarded for this request unless otherwise noted.