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ALLERGY
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OTOLOGY
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FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

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AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____

DATE: _____

RE: _____

DOB: _____

The above named patient has been in our office for evaluation and treatment. We understand you may have information that may be of help to us. We ask that you please forward the requested records as soon as possible. If you do not have the records or for some other reason cannot comply, please contact us.

_____ **Complete medical records (or summary if available)**
_____ **Audiograms**
_____ **Imaging/ex-ray report/films** _____
_____ **Other** _____

Thank you for your prompt attention.

Sincerely,

_____, M.D. Patient Signature _____

Guardian/Relationship _____