ENT & ALLERGY OF DELAWARE | COMPLETE CARE.

700 Prides Crossing
Suite 200
Newark, DE 19713
Attn: Medical Records
Phone: 302-998-0300×114
Fax: 302-543-8456
contactus@entad.org
www.entad.org

AUTHORIZATION TO RELEASE HEALTHCARE RECORDS

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Best Phone:_____ Last 4 digits of Social Security # :_____

I request and authorize ENT & Allergy of Delaware to release and send healthcare information for the above-named patient

RELEASE RECORDS TO: *(Where records should be sent)* ☐ Same as above

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

OBTAIN RECORDS FROM: *(Have records sent to ENT & Allergy of Delaware)*

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

SPECIFIC RECORDS TO BE SENT: *(Check all that apply)*

All Records: _____ or Specific Date: _____

☐ Progress/Office Visit Notes
☐ Laboratory/Pathology
☐ Tests (CT, MRI, X-Ray)
☐ Operative Testing
☐ Pulmonary Function Test
☐ Allergy Testing
☐ Audio Testing
☐ Other_____

Signature: _____ **Date:** _____
(Patient, Parent, or Guardian)