Alexiou Hearing and Sinus Center
2062 Pro Pointe lane
Harrisonburg VA 22801
Phone: 540 434-2255 Fax 540 434-8778

REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Dear Doctor _____:

_____ The following individual has asked us to release his/her records **to** your office. We have included all relevant information from our files.

_____ The following individual has asked us to request his/her medical records **from** your office, please include all relevant medical records in your file.

Patient Name: _____

Birthdate: _____ SSAN :_____

I hereby authorize the release of all necessary medical records to: _____

_____

Patient's Signature: _____ Date: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Signature of Witness: _____

This authorization shall be in effect for 90 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.