CONNECTICUT
EAR·NOSE·THROAT
MEDICAL AND SURGICAL SPECIALISTS, P.C.
Tom K. Coffey, M.D. Adam W. Pearl, M.D.

MEDICAL RECORDS REQUEST

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE: _____

DATE OF BIRTH: _____

PLEASE RELEASE: ☐ All Medical Records (includes office visit notes, lab results, hearing tests, etc.)

-OR-

☐Office Notes only
☐Lab Work only
☐Hearing Tests only

PLEASE SEND MY RECORDS TO: _____

_____

_____

SIGNED: _____

DATE: _____

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