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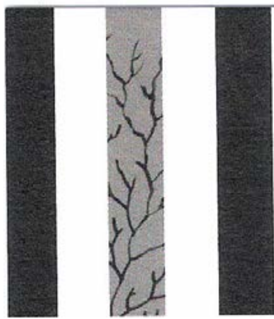

TODD BERINSTEIN, MD, JD, FACS

DAVID BLOOM, MD

Physicians, Surgeons, Consultants

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2101 NE 139th St, Suite 285

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(360) 326-3966

Fax (360) 859-3807

REQUEST FOR RECORDS RELEASE

The following individual has authorized the release of his or her medical records.

Patient Name: ____

Birthdate: ____________________ Social Security Number: ____________________

Release From:

☐ ENTOffice.org 2101 NE 139th St, Suite #285 Vancouver, WA 98686 Phone: 360.326.3966 Fax: 360.859.3807	☐ Clinic Name: ____________________ Address:____________________ City, State, Zip:____________________ Phone: ______________ Fax: ______________

Release To:

☐ ENTOffice.org 2101 NE 139th St, Suite #285 Vancouver, WA 98686 Phone: 360.326.3966 Fax: 360.859.3807	☐ Clinic Name: ____________________ Address:____________________ City, State, Zip:____________________ Phone: ______________ Fax: ______________ ☐ Release to Self

Permission:

☐ Release All Records on File	
☐ Chart Notes (If not all, indicate date(s) of service):	From date(s) of service: ____________
☐ Imaging (If not all, indicate date(s) of service):	From date(s) of service: ____________
☐ Lab /Bloodwork (If not all, indicate date(s) of service):	From date(s) of service: ____________

I hereby authorize the release of all necessary medical records to or from ENTOffice.org, as indicated above.

Patient's Signature: ______________________________________ Date: ________________

(or parent if patient is a minor)