Greater Philadelphia Ear Specialists, P.C.

Patient Name: _____

Date of Birth: _____

MEDICAL RECORDS RELEASE
FROM GREATER PHILADELPHIA EAR SPECIALISTS, P.C.

I, _____, authorize the release of my medical records from Greater Philadelphia Ear Specialists, P.C.

Please send copies of my medical records to:

_____

_____

_____

_____

Thank you.

_____
(Signature)

_____
(Date)

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