MIDWEST CENTRE

Martin L. Willman, M.D.
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Medical Records Release Form

Date:_____

I hereby authorize **MIDWEST ENT CENTRE**

to release copies of: **(Check all that apply)**

( ) Labs
( ) Audiogram/ENG
( ) Sleep Study
( ) Operative Report
( ) Pathology Report
( ) CT Scan/MRI/Thyroid Ultrasound/FNA
( ) Allergy Test Results
( ) ALL RECORDS

Patient Name:_____

Date of Birth:_____/_____/_____ Phone:_____/_____/_____

Address: _____

_____

To the following:_____

_____

Phone: _____ Fax:_____

Signature of patient or legal guardian:_____

*NOTE: ALL MEDICAL RECORD REQUESTS WILL TAKE 3-5 BUSINESS DAYS FROM THE DATE SIGNED REQUEST IS RECEIEVED. IF YOU HAVE AN UPCOMING APPOINTMENT WITH ANOTHER PHYSICIAN YOU WILL NEED TO ALLOW ENOUGH TIME FOR THE RECORDS TO BE TRANSFERRED. Thank you!

Please fax signed form to (636) 441-8072 or mail it to 4790 Executive Centre Pkwy St Peters, MO 63376- Attn: Medical Records
For Medical Records questions please Email TLehman@Mid-WestENT.com or call (636) 441-3100 Ext. 252

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