Request for Release of Medical Records

To Whom It May Concern:

I request copies or summaries of the medical records for:

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Date of Birth: ______________________________ Phone Number: ______________________________

To our office:
Dr. Paul Lenkowski
Roanoke Valley ENT and Allergy
2154 McVitty Road, Roanoke, VA 24018
Phone: (540) Your ENT (968-7368)
Fax: 1-844-212-0402

____ ____________________
Patient's Signature: Date:

Thank you!
Dr. Paul Lenkowski
Roanoke Valley ENT and Allergy