



Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

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DATE: _____

MEDICAL RECORD INVOICE

PATIENT DATA

NAME _____

ADDRESS _____

PHONE _____

SSN _____ - _____ - _____ DOB: _____

SIGNATURE _____

Please accept my signature above as my written authorization to release any and all medical records your office has on file for me or my child, and release photocopies to the designee below.

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