

East Tennessee Ear, Nose and Throat Specialists, PC

TO WHOM IT MAY CONCERN:

I, _____, the undersigned authorize the release of my medical record **by** the East Tennessee, Ear, Nose & Throat Specialists, P.C. 800 Oak Ridge Turnpike, Suite C-100, Oak Ridge, Tennessee to _____.

Signed _____
(If patient is a minor or for reasons unable to sign.)

Closest relative or guardian

Patient's Date of Birth _____

Witness _____

Date _____