

**Wilkinson Snowden Otolaryngology Consultants, PA**

**Albert H. Wilkinson, III, MD**

**R. Todd Snowden MD**

**REQUEST FOR MEDICAL RECORDS**

RELEASE OF RECORDS

***Patient Information:***

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Patient's SS#: \_\_\_\_\_

***Records to be sent to following address:***

Wilkinson Snowden Otolaryngology Consultants, PA  
14546 St. Augustine Road, Ste 401  
Jacksonville, FL 32258  
Phone (904) 268-5366 Fax (904) 268-5457

***Reason for Transfer of Records*** \_\_\_\_\_

***Records to be received from:***

Physician/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**ALL PATIENT INFORMATION IS CONFIDENTIAL AND PRIVILEGED**

The confidentiality of patient records is protected by Federal Law. Federal Law prohibits the recipient from making any further disclosure. A general authorization for the release of medical information is not sufficient for this purpose.

**As part of the medical record, the following will be released unless stricken:**

- Sexual Abuse Information
- Drug and Alcohol Abuse Information
- Child Abuse and Neglect Information
- Psychiatric Information
- AIDS/HIV

**I acknowledge that I have read this authorization and fully understand its contents.**

**Signed:** \_\_\_\_\_  
**Patient, Parent, or Guardian**

\_\_\_\_\_  
**Date**

**Witness:** \_\_\_\_\_

\_\_\_\_\_  
**Date**