advanced
EAR, NOSE & THROAT
head and neck surgery

Randall S. Lomax D.O.

Request for Records

Patients: Please list any previous providers so we may retain medical records.

Date:______________________

Physican:_____________________________________

Speciality:____________________________________

Phone:________________Fax:_________________

Office Use only

☐ Copies of Blood Work Within the last _____months

☐ Medical Records in the last _____ months

☐ All radiology reports

Physican:_____________________________________

Speciality:____________________________________

Phone:________________Fax:_________________

☐ Copies of Blood Work Within the last _____months

☐ Medical Records in the last _____ months

☐ All radiology reports

I,_____________________________ hereby authorize you to release all of the above records to Dr. Randall S. Lomax. This request expires 12 months from date signed.

____
Patient, Parent, or Guardian Signature

____
Please Print Name

____
Date of Birth

____
Relationship to Patient