



Orlando Ear, Nose & Throat Associates, P.A.

Medical Records Request

Name of Patient _____ DOB _____

Person making request (if patient is a minor) _____

Contact Phone Number(s) _____

Doctor (circle) BIBLIOWICZ HARRINGTON RABAJA

Where the records should be sent:

Name:

Address:

All requests will be processed and sent within 72 hours. Fees will be charged according to state and federal law. Fees will be collected at the time of mailing. Current fee schedule available by request.

Orlando office fax 407 282 5483 **Oviedo** office fax 407 971 3341