



JEFFREY ADELGLASS, M.D., F.A.C.S  
GREGORY D. ROBERTS, M.D.

EAR, NOSE & THROAT • ALLERGY • FACIAL PLASTIC SURGERY

## REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

I hereby request medical records be released:

**To / From**  
(please circle one)

**Jeffrey Adelglass, M.D., F.A.C.S.**

**Gregory D. Roberts, M.D.**

6020 W. Parker Road, Suite 400  
Plano, TX 75093  
972-492-6990 (ph)  
972-394-4405 (fax)

**To / From**  
(please circle one)

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

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

**Reason:** \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature  
or patient's parent or legal guardian

\_\_\_\_\_  
Date