

Robert H. Oliver, M.D. , PLLC
Otolaryngology - Head and Neck Surgery & Otolaryngic Allergy

Permission of Records Release

I _____ Date of Birth _____

Give authority for a request of my records to be exchanged
Between Robert H. Oliver, M.D.
At 1295 Portland Avenue. Suite # 24 Rochester, NY 14621

And _____.

Thank you.

Patient/Parent Signature: _____ Date: _____

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