MEDICAL RECORDS RELEASE/REQUEST

Patient Name:_____

Date of Birth:_____ SS#: XXX-XX-_____

Patient Phone Number:_____

(circle option)

I hereby authorize ENT of Georgia to release/obtain my health information (circle option)
to/from:_____

Address:_____

City, State & Zip:_____

Phone:_____ Fax:_____

Specific Information to be Disclosed:

____Labs ____Surgical Notes ____CT/MRI or Imaging Reports

____Hearing/Audio Exams _____Sleep Studies _____All Records

____Other_____

Purpose of the Disclosure:

____Continuing Care ____Personal ____Insurance ____Legal ___Other

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

Please allow 7-10 days for processing of records requested. I agree to pay charges if applicable.

I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to ENT of Georgia. Unless withdrawn, this consent will expire 90 days from the date signed.

_____ _____
Patient Signature Date

Delivery Method:____Pick Up _____Mail _____Fax:_____
to the following location, Attention:_____