AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please print):

Name: ______________________________ DOB: ______________

Social Security No: ____________________ Phone: ________________

Address: ____

City: ________________ State: __________ Zip code: ________

RELEASE MY MEDICAL RECORDS FROM:
East Alabama Ear, Nose, and Throat, P.C.
1965 First Avenue
Opelika, AL 36801

Phone: (334) 364-0356
Fax: (334) 705-0378

(Circle) Dr. William Blythe Dr. Warren Stiles Dr. Stites Whatley

TO: NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

FAX: ______________________________

Please release a copy of all my medical records, including, but not limited to: office notes, operative notes, laboratory results, x-ray reports, audio reports, audio-verbal notes (AVT), etc. or just: ____

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This authorization expires on no specific date unless otherwise stated; I understand I have the right to revoke this authorization at any time: exp. date ______________

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: ______________________ Date: ________________

Parent or guardian (please circle)

Due to HIPPA regulations, no miscellaneous records can be released such as any medical record received in this office from another doctors' office, hospital, diagnostic center, etc. No records will be copied prior to the year 2000. HIPPA regulations require medical facilities to keep records for 10 years. If chart is voluminous, patient could be required to pay copying costs and/or storage fees, which needs to be paid in cash prior to retrieving/copying of records.