



Authorization to Release Medical Records

Patient Information (Please print):

Name: _____ DOB: _____

SSN: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Release my medical records FROM:

East Alabama Ear Nose & Throat, P.C.

1965 1st Avenue, Opelika, AL 36801 Phone: 334-705-0012 Fax: 334-705-0378

Dr. William Blythe Dr. Warren Stiles Dr. Stites Whatley

Dr. Luke Bailey Dr. William Ruffin

TO:

Name: _____

Address: _____

Phone: _____

Fax or Email: _____

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

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 HIPAA regulations; no miscellaneous records can be released such as any medical record received in this office from another doctor's office, hospital, diagnostic center, etc. No records will be copied prior to the year of 2000. HIPAA 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 prior to retrieving/copying of records.