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. **Phone: (334) 364-0356**
1965 First Avenue **Fax: (334) 705-0378**
Opelika, AL 36801

(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:_____

_____

_____

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.