NORTH ALABAMA ENT ASSOCIATES, P.C.
927 Franklin Street, Suite 100 Huntsville AL 35801 (256) 536-9300 Fax: (256) 535-9032

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/RECORDS **TODAY'S DATE:**

PATIENT NAME IN FULL ____M ____F	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
STREET ADDRESS, CITY, STATE, ZIP CODE			TELEPHONE NUMBER(S) Home:____ Cell:____

I hereby authorize North Alabama ENT Associates, P.C. to (Please Check):______*RELEASE* ______*OBTAIN* information and copies or records pertaining to my medical care and treatment.

I request my medical records (Please Check): ______Entire Chart ____Other, Specify________

RELEASE TO / OBTAIN FROM	
Name	
Address	
Phone Number	Fax Number
COST FOR COPIES: **Page(s) 1-25 $1.00 per page If mailed, current postal rate**	**Each Subsequent Page (26 and above) $0.50** **$5.00 Administrative Fee**

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG/SUBSTANCE OR ALCOHOL ABUSE.

I understand that if I am requesting records/information for release to me or patient or patient representative:

- In certain situations records denied for release to the patient may allow patient to request and obtain a review of the denial

This Authorization:

- will expire in 12 months or ________
- may be revoked in writing, care of Medical Records Custodian, accord to the Facility's Notice of Privacy Practices. Prior disclosures will not be affected
- is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.

RELEASE: I RELEASE North Alabama ENT Associates, P.C., its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

PHOTO ID IS REQUIRED WHEN AUTHORIZATION SIGNED AND RECEIVING MEDICAL RECORDS.

MEDICAL RECORDS ON PREMISES WILL BE AVAILABLE TEN (10) WORKING DAYS AFTER AUTHORIZATION SIGNED. MEDICAL RECORDS IN STORAGE AVAILABLE FOR PICKUP THIRTY (30) DAYS AFTER AUTHORIZATION SIGNED.

PATIENT SIGNATURE________________ DATE________

PERSON AUTHORIZED TO SIGN FOR PATIENT SIGNATURE________________

REASON PATIENT UNABLE TO SIGN________________ RELATIONSHIP TO PATIENT________

EMPLOYEE SIGNATURE RECEIVING FORM & COPY OF PHOTO ID ________________ DATE________

RECEIPT OF MEDICAL RECORDS:

SIGNATURE OF PATIENT/AUTHORIZED RECEIVING MEDICAL RECORDS________________ DATE________

OFFICE USE ONLY

PHYSICIAN APPROVAL (IF APPROPRIATE)________________ DATE________ APPROVED____ DENIED____

PRIVACY OFFICER (IF APPROPRIATE)________________ DATE________ APPROVED____ DENIED____

SIGNATURE OF EMPLOYEE COMPLETING REQUEST________________ DATE________

____In Person ____Mailed ____Faxed ____Copy of Photo ID