



MEDICAL RECORDS RELEASE/REQUEST FORM
North Alabama ENT Associates, P.C.
1963 Memorial Parkway SW, Suite 5
Huntsville, AL 35801
Phone (256) 536-9300
Fax (256) 535-9032

Patient Name _____ Date of Birth _____

Address _____

Phone # _____ Email _____

I hereby authorize North Alabama ENT Associates, P.C to RELEASE or OBTAIN from the following, information and copies or records pertaining to my medical care and treatment.

Please release: Entire Chart or Other _____

Name _____

Address _____

Phone # _____ Fax# _____

Email _____

The information authorized for release may include information which may indicate the presence of communicable or non- communicable disease, or relate to mental health, or drug/substance or alcohol abuse.

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.

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.

I release North Alabama ENT Associates, P.C., its employees and agents form 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 WILL BE AVAILABLE TEN(10) WORKING DAYS AFTER AUTHORIZATION SIGNED

COST FOR COPIES OF YOUR MEDICAL RECORDS ARE: Pages 1-25=\$1.00 per page, 26 and above=\$0.50 per page, \$5.00 Administrative fee, if mailed, cost of postage will also be applied.

Patient Signature _____ Date _____

Person Authorized to sign for patient _____

Reason patient unable to sign _____ Relationship to patient _____

Employee signature receiving form & copy of photo ID _____ Date _____

Signature of employee completing request _____ Date _____

 In person Mailed Faxed Emailed