EAR, NOSE & THROAT INSTITUTE
The Center of Excellence for Ear, Nose & Throat Disorders

Medical Records Release Form

Patient Name _____ Date of Birth _____

A.) I authorize ENT Institute/Milton Hall Surgical Associates to **RELEASE** copies to:
Name: _____
Address: _____ City: _____
State & Zip: _____ Phone: _____ Fax: _____

B.) I authorize ENT Institute/Milton Hall Surgical Associates to **OBTAIN** copies from:
Name: _____
Address: _____ City: _____
State & Zip: _____ Phone: _____ Fax: _____

Check the information that may be released. (Please note that only records that have been ordered by our office may be released.)

❏ Complete Chart ❏ Lab Results ❏ Surgery Notes
❏ Audiology Notes ❏ CT/MRI Films and Reports ❏ Billing Statements
❏ Sleep Study Results ❏ Other:_____

This is to be:
❏ Picked Up ❏ Mailed
❏ Faxed to: _____

I hereby authorize this practice to release my medical records, including, but not limited to all the above. By signing this consent I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months.

Patient/Guardian's Signature: _____ Date: _____

Pursuant to O.C.G.A. § 31-33-3, effective July 1, 2016, the costs related to Medical record retrieval, certification and copying are listed below. Reviewed for accuracy/updates on 12/15/2016.
Copying Costs for Records in paper form:
- Certification Fee (up to per record): **$9.70** .
- Per page for pages 1-20: **$0.97** .
- Per page for pages 21-100: **$0.83** .
- Per page for pages over 100: **$0.66** .

For Office Use Only

Payment Amount: _____ Paid on: _____ Payment Method: _____

Records Sent on: _____ Initial: _____

Physicians Signature: _____