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
❑ Audiology Notes
❑ Sleep Study Results
❑ Lab Results
❑ CT/MRI Films and Reports
❑ Surgery Notes
❑ Billing Statements
❑ Other:__________________

This is to be:
❑ Picked Up
❑ Mailed
❑ Emailed to: _______________________
❑ 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, 2018, the costs related to Medical record retrieval, certification and copying are listed below.

Copying Costs for Records in paper form:
- Certification Fee (up to per record): **$9.70** .
- Search, Retrieval and Direct Administrative Costs: **$25.88**
- 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: ___________________