Advanced
EAR NOSE & THROAT ASSOCIATES

MEDICAL RECORDS RELEASE

Patient Name: ____

Date of Birth: ______________________

I hereby authorize the release and transfer of confidential personal health information contained in the above-named patient's medical record, including information about treatment of physical or mental illnesses, chemical dependency, alcohol abuse, testing or treatment for any communicable or infectious diseases such as Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Tuberculosis, Hepatitis, or COVID-19. I understand that this consent may be revoked at any time by me with written notice to the involved parties unless the revocation is received after the records have been released. This authorization will expire ninety (90) days from the date signed unless otherwise specified below. I release the office and its physicians, employees, and agents from all liability in complying with this request.

All files in record Date: ____

Office notes Date: ____

Laboratory data Date: ____________________ Type: ______________________________

Sleep studies Date: ____

Operative report Date: ____________________ Type: ______________________________

Pathology report Date: ____________________ Type: ______________________________

Imaging studies Date: ____________________ Type: ______________________________

Other: ____

The requested information above is to be transferred:

To From ATTN:____

Advanced Ear, Nose, and Throat Associates, PC
960 Johnson Ferry Road NE, Suite 200
Atlanta, GA 30342
Phone: (404) 943-0900
Fax: (404) 943-1390

To From ____

____

Reason for disclosure: ____

Signature: ____ Date: ______________________

Patient or Legal Guardian if Patient is a Minor

Witness: ____ Date: ______________________