Authorization for Release of Medical Information

Date:_____

Name:_____ DOB:_____

Address:_____

_____

Phone#_____

I hereby authorize (please list physician name and/or facility):

Physician's Name:_____

Facility Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

To release my records to Georgia Center for ENT. You can fax them to 678.815.1548 or if greater than 20 pages mail the records to Georgia Center for ENT at 1106 Hospital Drive Stockbridge, GA 30281.

_____All records _____CT/Ultrasound _____Sleep Study

_____Audio Testing _____Labs _____Surgery OP notes & Pathology

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

_____ _____

Signature Date

Thank you for your help in this matter. If you have any questions or need any further assistance please contact our office at 678.902.9495.