Pappas Ear Clinic, P.C.

Authorization to Release Medical Information

Patient Name: _____

Date Birth: _____

- I authorize the Pappas Ear Clinic, P.C. to use or release the above named individuals medical information for the purpose of:
  - ☐ Continuation of Medical Treatment
  - ☐ Workers Compensation
  - ☐ Legal Purposes
  - ☐ Insurance Purposes
  - ☐ At the request of the patient or the patient's legal representative for personal access or other (specify): _____
- The type and amount of information to be disclosed is as follows:
  - ☐ Most recent office notes
  - ☐ Most recent operative note
  - ☐ Itemized statement of account
  - ☐ MRI or CT report
  - ☐ Audiology report
  - ☐ Entire Record
- Records/ Films to be obtained from:

Physician: _____

Hospital/ Facility: _____

- I understand that this information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

Pappas Ear Clinic, P.C.
2937 7th Ave South
Birmingham, Al 35233
Office (205)-251-7169
Fax (205)-254-3013

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Pappas Ear Clinic, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six months.

- I understand that authorizing the disclosure of this medical information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. i understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If signed by Legal Representative, Relationship **Signature of Witness**

Medical Records Fees

Medical Records faxed directly to Doctor: **No charge**

Medical records sent elsewhere: **$1.00** per page for the first 25 pg
$0.50 per page for each page in excess of 25 pg
$5.00 Search Fee
Cost of mailing

Disability, FMLA, School Letters, Jury Duty, or Physician Letter

$40.00 charge
There will be an additional **$5.00** charge for any additional records to be done

Fees must be paid prior to forms being completed

Please allow **7 days** for return of these forms