



The ENT Center of Central Georgia

540 Hemlock Street
Macon, GA 31201
Tel: 478-743-8953
Fax: 478-743-1963

6084 Lakeview Rd
Warner Robins, GA 31088
Tel: 478-333-2235
Fax: 478-333-2238

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print):

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

RELEASE MY RECORDS TO:

Name: _____

Telephone: _____

Fax: _____

FROM: Name: _____

Telephone: _____

Fax: _____

Information to be disclosed: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under Federal Law, for the sole purpose and time period below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Patient/ Guardian: _____ Date: _____

Relationship to Patient: _____