ENT Associates of South Atlanta, LLC

1170 Cleveland Ave, East Point, GA 30344-3615
Phone (404)768-9350
Fax (404)768-2530

Authorization to Release Information

RE: ______________________ D.O.B: __________ SSN: __________________

Address: ____

Print name of Parent/Guardian (if request is for a minor) ____________________________

Information Requested/Released:
( ) Evaluation/Progress Notes
( ) Lab and/or Radiology tests
( ) Surgery Records
( ) Other: ____
( ) **I DO NOT** consent to the release of information

I hereby request and authorize **ENT Associates of South Atlanta** to **release** any and all information indicated **to**:

Name: __________________________________

Address: ________________________________

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Telephone: ______________________ Fax: ______________________

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect for up to one year from this date.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Date: ____________ Signature of Client/Guardian: __________________________

Date: ____________ Signature of Witness: __________________________

NON-COVERED SERVICES AGREEMENT

Fees for ancillary services such as copies of medical records, reports, third-party letters, medical leave forms, formulary questions and appeals, etc. are not covered by most insurance plans. Fees for these services are defined by ENT Associates of South Atlanta, LLC and are based on copy costs and the amount of time required by clinical and administrative staff. The following rates will apply:

Standard $25.00 (5 pages maximum)
Extensive: + $0.82 per page

I understand that this is a non-covered service based upon my current insurance benefits and is to be paid at the time of service and is not reimbursable by my insurance plan.

Signature: ______________________________ Date: ____________