Dr. Matthew T. Gill
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Suwanee, GA 30024
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MEDICAL RECORDS RELEASE/REQUEST

Patient Name:_____Date of Birth:_____ SS# (last 4):_____

Patient Phone Number: _____

(circle option)

I hereby authorize Suwanee ENT to release / obtain my health information

To/From:_____

Address:_____

City, State & Zip:_____

Phone:_____ Fax:_____

Specific information to be disclosed:

____ Office Visit Notes ____Operative Report(s) ____ Imaging Report(s) ____Pathology Report(s)
____Hearing Tests/Audiology Exams ____ Labs ____Sleep Studies

____**ALL RECORDS**

Other_____

Purpose of the Disclosure: ____Continuing Care ____Personal ____Insurance ____Legal ___Other

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable. Please allow 7-10 days for processing of records requested. I agree to pay charges if applicable. I understand that once the above information is disclosed it may be subject to redisclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Suwanee ENT. Unless withdrawn, this consent will expire 90 days from the date signed.

Patient Signature_____ Date _____

Delivery Method: ____Pick Up _____Mail _____Fax:_____ Attention: