



CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

6035 Fairview Road, Charlotte, NC 28210
Office: 704.295.3000 Fax: 704.295.3033
GoodSenses.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1) Print Patient's Full Legal Name: _____ Date of Birth: _____
Street Address: _____ Phone Number: _____
City State Zip Code: _____ Mobile Number: _____

2) I, (name of patient/legal guardian) _____, do hereby authorize
 Charlotte Eye Ear Nose & Throat Associates or
 Outside Source (Provider/Physician): _____
Address: _____
Address: _____
City State Zip Code: _____
Phone Number: _____ Fax Number: _____

to release my Health Information as defined below: (check one)

All Medical records for the last 5 years
 Medical records from _____ (date) to _____ (date)
 All Medical records EXCEPT _____
List conditions, treatments, or type of medical records

I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

3) Information is to be disclosed to:
 Charlotte Eye Ear Nose & Throat Associates, 6035 Fairview Road, Charlotte, NC, 28210 Fax (704) 295-3033 OR
Forwarded to the Attention of: _____
Address: _____
Address: _____
City State Zip Code: _____
Phone Number: _____ Fax Number: _____
Purpose of Disclosure:
 Insurance other than medical Change of Physician Personal Legal Investigation Disability Determination
 Other _____

4) I understand that if the person or organization I authorize to receive my Protected Health Information is not a health plan or healthcare provider, my health information may no longer be protected by Federal privacy regulations once it is disclosed.

Signature of requestor or Parent/Legal Guardian/Authorized Representative for Minor (under 18 years of age) _____
Date Signed

Charge of Medical Records Are as Follows: Archivus has been contracted to provide the service of processing medical records request.

No charge due to records being forwarded to referring provider, workers comp or medical insurance company

Note: All records dated prior to 1/1/2003 a \$10.00 fee will be charged.

\$15.00 Charge for records dated after 1/1/2003 (Payment accepted is cash or check payable to Archivus – attach payment to release)

\$25.00 Charge for records over 75 pages (Payment accepted is cash or check payable to Archivus – attach payment to release)

Additional Charge of \$10.00 for any record dated prior to 1/1/2003 (Payment accepted is cash or check payable to Charlotte Eye Ear Nose & Throat)

Total Funds Collected \$ _____ Payment type Cash Check