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

Patient Name: _____
(Last) (First) (Middle) (Maiden)

Street Address: _____ SSN: _____ (optional) Date of Birth: _____

City, State, Zip: _____ Telephone: ( ) _____

E-mail Address: _____ Are you a veteran? ☐ Yes ☐ No

Release Information From:		**Release Information To:**	
(Name of facility, person, company)	(Relationship)	(Name of facility, person, company)	(Relationship)
(Street address or PO Box)	(Phone Number)	(Street address or PO Box)	(Phone Number)
(City, State, Zip)	(Fax number)	(City, State, Zip)	(Fax number)

Purpose of Release (check reason): ☐ Request of individual/Personal ☐ Insurance ☐ Continued patient care ☐ Legal
☐ Other:_____

Medical Records Release: *****A $10.00 charge will be collected prior to release of records*****

☐ All medical records from _____ (Date) to _____ (Date). ☐ All medical records for the last 3 years

☐ All medical records ☐ EXCEPT _____
(List conditions, treatments or type of medical records)

☐ I DO NOT authorize release of information related to AIDS/HIV, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

Delivery Method (only select one): ☐ US Mail ☐ Pick-up location: _____ ☐ Fax: _____ (Fax number)
☐ Other:_____ **Date of upcoming appointment:** _____

I understand that if the person or entity that receives this information is not a health plan or a health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.
*I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted diseases, HIV/AIDS and/or Aids related complex (ARC). This authorization will expire in 365 days unless otherwise noted.

Signature: _____ **Date:** _____

Print Name: _____

☐ Patient or authorized representative (must provide POA paperwork):☐ Guardian ☐ Parent ☐ Other: _____

*Please note: The information following the asterisk above applies to minors as well as emancipated minors.

Signature of Minor: _____ **Date:** _____

Print Name: _____

Please allow 7-10 business days to process your request.

Medical Records Department is located at 724 Aubrey Bell Dr, Matthews, NC 28105-5055
Office: 704-295-3030 Fax: 704-295-7794 Email: mremail@ceenta.com