

BURSON ENT

2080 Newnan Crossing Blvd

Suite 200

NEWNAN GA 30265

Patient Name : _____ DOB: _____

MEDICAL RECORDS REQUEST FEE

The office of **James G. Burson , M.D.** will provide your records to you once you have completed the Patient Authorization for Use/Disclosure of Protected Health Information (PHI) form. You can find this form on our website or you can contact our office and we can Mail or fax the form to you. **Please be sure to sign the form. Unsigned requests cannot be processed.**

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the Records to the information you provide on the authorization form.

Listed below are the charges for copying medical records:

Search/ Retrieval	\$25.88
Pages 1 – 20	.97 per page
Pages 21-50	.83 Per Page
Pages 51 or more	.66 Per Page

FORM AND LETTER FEE

This is to notify you that the office of **James G. Burson , M.D.**, will apply a fee of \$75.00 to your account for patients, companies, family members, insurance carriers or other people requesting form /or letters to be completed.

Forms include, but not limited to **FMLA**, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, ect. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, ect.

In order to comply with federal laws including HIPAA, as well as Georgia federal statutes, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office and we can mail or fax it to you. **Please be sure to sign the form. Unsigned requests cannot be processed.**

Signature of patient or responsible party

_____ DATE: _____