BURSON
Ear, Nose, & Throat

James G. Burson, M.D.

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please print your doctor's name, address, phone number and fax number, if known. If information is unavailable, the first and last name of the doctor is acceptable.

Doctor's Name: _____

Doctor's Address: _____

City, State, Zip: _____

Phone/Fax number: _____

To comply with HIPPA regulations regarding minimum necessary, please forward a copy of my medical records that pertains to one or more checked below:

a) Audiology: _____

b) Diagnosis: _____

c) Complete Chart: _____

d) Imaging: _____

e) Labs: _____

Burson ENT
2080 Newnan Crossing Blvd
Suite 200
Newnan, GA 30265
Phone: 770-955-0272
Fax: 770-955-0273

Patient Name: _____

Date of Birth: _____

Signature: _____

Relationship to Patient: _____