CALIFORNIA HEAD & NECK SPECIALISTS
EAR, NOSE & THROAT CENTER

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize: _____ **Physician/ Healthcare Facility**

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Address, City, State, Zip: _____

The medical information/records will be used for the following purpose: _____

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)

HIV Diagnosis/Treatment _____ (initial)

Psychiatric/Mental Health _____ (initial)

Genetic Information _____ (initial)

Tests for Antibodies to HIV _____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect until this date: _____

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of the facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

FEE

There is a processing fee in the amount of $25 for any medical records request. This fee will be waived if California Head & Neck Specialists/ Blue Illusion Beauty is sending directly to another provider. Please allow 10-15 days for your request to be processed.

Signature of patient or legal/personal representative _____

Relationship if other than patient _____