



Head and Neck Associates of Orange County, Inc.

An Incorporated Medical Group

Head & Neck Surgery

Pediatric & Adult Otolaryngology

Facial Reconstructive Surgery

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

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Head and Neck Associates of Orange County to release information regarding my medical history, illness or injury, consultation, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by mean of mail, fax or methods.

To/or myself: _____

This authorization is:

All the records (excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

Portion of records concerning: _____

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

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

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 or 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.

Signature of patient

Relationship if other than patient

Patient's Name

Date of Birth

Telephone Number

Date

I would like the information delivered via the following format:

Paper copy US Mail

Address _____

Paper copy, office pickup (Mission Viejo only)

Fax Number/Name: _____