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Diplomates, American Board of Otolaryngology

Head & Neck Surgery      Pediatric & Adult Otolaryngology      Facial Reconstructive Surgery

**Authorization for Release of Medical Records**

I hereby request and authorize the physicians of Head and Neck Associates of Orange County to furnish medical information concerning:

\_\_\_\_\_  
 Patient's Name

\_\_\_\_\_  
 Patient's Date of Birth

To: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Name and Address

I authorize that any and / or all information may be released, including but not limited to mental health records protected by the Lantermen-Petris-Short Act, drug and / or alcohol abuse records and / or HIV test results, if any, except as specifically listed below:

**Excluded records:**

\_\_\_\_\_  
 \_\_\_\_\_

This authorization is effective now and will remain in effect until \_\_\_\_\_  
 Date

I understand that I have the right to receive a copy of this signed authorization.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

10-08; bp

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