Head and Neck Associates of Orange County, Inc.

An Incorporated Medical Group

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: ____

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)	Tests for Antibodies to HIV	______ (initial)
Psychiatric/Mental Health	_____ (initial)	HIV Diagnosis/Treatment	______ (initial)

DURATION This authorization shell be effective immediately and remain in effect until _________

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

_____________________________________ Date

I would like the information delivered via the following format:

[ ] Paper copy US Mail [ ] Paper copy, office pickup (Mission Viejo only)

[ ] Fax Number/Name: ____