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)

REASON FOR REQUESTING RECORDS: _____

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: _____

[ ] email _____