ENT Associates of San Diego
Ear, Nose and Throat Associates of San Diego
A Medical Corporation

Otolaryngology for Adults and Children
Head and Neck Surgery

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL 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 for ____
Name Date of Birth

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: ____
Name

____
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)
Psychiatric/Mental Health ______ (initial)
Tests for antibodies to HIV ______ (initial)
HIV Diagnosis/Treatment ______ (initial)
Genetic Information ______ (initial)

DURATION

This authorization shall be effective immediately and remain in effect until ________________.
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 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 *or legal/personal representative*	Relationship *if other than patient)*
____	____________________________
Patient's Name (PRINT)	Date
____	____________________________
Patient's Social Security Number	Patient's Date of Birth
____	____________________________
Witness's Name	Signature of Witness