San Diego ENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____

Date of Birth: _____

Person(s) authorized to receive the information:

_____

_____

_____

_____

Type of record: _____

Patient's Signature: _____

Today's Date: _____

CONFIDENTIALITY NOTICE:
THIS DOCUMENT/FAX MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION. THE INFORMATION IN THIS DOCUMENT/FAX IS INTENDED FOR A SPECIFIC INDIVIDUAL AND PURPOSE. THIS INFORMATION IS PRIVATE AND PROTECTED BY LAW. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT THIS IS UNLAWFUL FOR UNAUTHORIZED PERSONS REVIEW, COPY, DISCLOSE, OR DISSEMINATE CONFIDENTIAL MEDICAL INFORMATION. IF YOU HAVE RECEIVED THIS DOCUMENT/FAX MESSAGE IN ERROR, PLEASE NOTIFY US IMMEDIATELY AT THE TELEPHONE NUMBER INDICATED BELOW AND RETURN THE ORIGINAL MESSAGE TO US BY MAIL.

Phone 858-926-7010 · Fax 858-926-7011
4150 Regents Park Row, Suite 345, La Jolla, CA 92037