AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL RECORDS

Treatment will not be conditioned on my providing or refusing to provide this authorization.
I hereby authorize and request:

_____

(Name of Healthcare Provider, Phone, Fax)

To release medical records in their possession
To: San Diego ENT/UNITED MEDICAL DOCTORS
FAX: 858-926-7011

Release and/or disclose records and information regarding:

_____ / _____ / _____

Name of Patient (print) | Date of Birth | Medical Record # (if known)

SPECIFIC RECORDS TO BE RELEASED AND/OR DISCLOSED:

- ☐ General Medical Information
- ☐ Past Procedures
- ☐ Other:
- ☐ Labs
- ☐ Radiology: CT, Ultrasound, MRI
- ☐ Biopsy

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.
This copy is for me to keep.

_____ _____ _____

Signature of patient or patient's representative | Relationship (if not patient) | Date

DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.