CAMINO
EAR, NOSE & THROAT CLINIC

Authorization for Release of Medical Records

Your completion of this form means that you are giving permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity receiving your information to complete the sections detailing the information to be released and the purpose for the disclosure.

Patient Name _____ Date of Birth _____

Address _____ Phone _____

City, State, Zip _____

The above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name _____ Facility Phone _____

Facility Address _____ Facility Fax _____

City, State, Zip _____

Type of Information to Disclose:

- ☐ Complete Health Record(s)
- ☐ Laboratory Test Report
- ☐ Imaging/Report
- ☐ Audiogram(s)
- ☐ History & Physical
- ☐ Pathology Report
- ☐ Operative Report
- ☐ Clinical Note(s)
- ☐ CDX File (Cochlear Implant Recipients only)*
- ☐ Other (Please Specify) _____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (ex. VA Med Center)
- ☐ Referral
- ☐ Personal Use

Dates (If Applicable) _____

This information will be disclosed and used by the following individual or organization:

Release to _____

Address _____

City, State, Zip _____ ☐ Please mail records.

Phone _____ Fax _____ ☐ Please fax records.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

Signed (Patient or Legal Guardian) _____ Date _____

If legal guardian, please state relationship to patient _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization.

*CDX files can only be sent via email to an audiologist with access to the programming software for your device. Please provide an email above if you are requesting a transfer of this software file.