Authorization for Release of Medical Records

1. I hereby authorize _________________________ to disclose the following information to the California Sinus Centers and Institute from the health records of:

   Patient Name: _______________________________________ D.O.B.: _________________

   Facility Address: _________________________________ Phone: _______________________

   Covering the period(s) of healthcare:

   From (date) _____________________________ to (date) ______________________________

2. Information to be disclosed:

- □ Complete health record(s)
- □ Inpatient Progress Notes(s)
- □ Consultation Report
- □ Operative Report
- □ Radiology (X-Ray) Reports
- □ Other (please specify) ____
- □ Outpatient/Clinical Notes
- □ Pathology Report
- □ History & Physical
- □ Laboratory Test Reports

3. This information will be disclosed to the California Sinus Centers and Institute. Please mail or fax to:

□ 3351 El Camino Real, Suite 200
Atherton, CA 94027
(650) 399-4630 (phone)
(650) 366-4930 (fax)

□ 2123 Ygancio Valley Road, Bldg K-100
Walnut Creek, CA 94598
(925) 300-4680 (phone)
(925) 906-9780 (fax)

Please transfer requested information by this date: _______________________________

4. 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: __________________________________