
# Authorization for Release of Medical Records

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

Patient Name: _____ D.O.B.: _____

Address: _____ Phone: _____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____

2. Information to be disclosed:

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

Other (please specify) _____

3. This information will be disclosed to the following provider. Please mail or fax to (circle one):

Doctor's Name: _____

Address: _____

Phone number: _____ Fax number: _____

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: _____