AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____ Date of Birth: _____

Hereby request Dr. /Facility: _____

To send copies of my medical records to: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

The following information is to be released:

□ Office Visit – Date(s) of Service: _____
□ Pre-Op History & Physical - Date(s) of Service: _____
□ Operative Report - Date(s) of Service: _____
□ Lab Tests: - Date(s) of Service: _____
□ CT/MRI Reports - Date(s) of Service: _____
□ Other - (specify) _____

How would you like your records delivered? □ **E-mail** □ **Fax** □ **Paper copy**

Patient initials

_____ Patient requests records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases:

□ Q. VanderWerf, M.D. □ C. Walz, M.D. □ M. Wilson, M.D.
□ Kari Moeller, FNP-BC □ Mark Dome, P.A.

from responsibility for this fax. Fax Number: _____.

Patient initials

1. _____ I understand that the information in my health records may include information relating to sexually transmitted disease(s), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about the treatment for alcohol and drug abuse and/or behavioral or mental health services.

2. The recipient may use the medical records and type of information authorized only for the following purposes: □ Patient access □ Continuation of care
□ Application for Insurance □ Other: _____

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy and unless otherwise revoked, this authorization will expire on the following date, event or condition:

   _____.

   Failure to specify an expiration date, event or condition, this authorization will expire in 60 days.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Directors of Health information services.

5. Please be advised that there will be a fee to send your medical records. They can be sent to you either by e-mail, regular mail, or Fax. You may also pick them up from our office. *The following fee schedule applies:*

- Up to 10 pages will be free
- 11 pages or more, there will be a $25.00 fee for a *paper copy.*
- 11 pages or more, there will be a $15.00 fee for *e-mail, fax*. (Please allow 7-10 working days for your records to be copied and mailed.)

6. FOR URGENT RECORDS PLEASE ALLOW 48 HOURS FOR RECORDS TO BE COPIED.

Date: _____ Time: _____ A.M or P.M.

Signature: _____
(Circle one: patient / representative / spouse / financially responsible party)

Witness: _____

DESERT EAR NOSE & THROAT 71687 Highway 111, Suite 101
Rancho Mirage, California 92270
Phone: 760-340-4566 Fax: 760-340-2481