16100 Sand Canyon Ave, Suite 230 Irvine CA 92618
PHONE: 949-715-0500 FAX: 949-715-0504

Authorization for Confidential Information

Patient Name____ DOB ____________________

Previous Maiden Name ________________________________Phone # ________________________

I authorize **Orange Coast Head and Neck Surgery** to

____ Release my information **TO** ____ Request my information **FROM**

The following physicians, clinics, hospitals, and/or facilities:

Name, Phone, Fax #____

Name, Phone, Fax #____

Information Needed: □ ALL From date __________________ to ________________________

- Operative Notes and related Pathology
- Audiology/Hearing Studies and Reports
- Recent office visit notes (past 2 notes unless otherwise indicated)
- Recent Labs (within the past 2 months unless otherwise indicated)
- Imaging (CT, MRI, Xray, etc) _____________________________________
- Sleep Studies and/or CPAP reports
- Other ____

Specifically EXCLUDE ____HIV/AIDS ____ STD ____ Psychiatric disclosure

This information is for the treating specialist and should not be used for any other purpose.

I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by Orange Coast Head and Neck Surgery unless I withdraw my consent during treatment. This consent will expire 365 days after my last visit date, unless Orange Coast Head and Neck Surgery is otherwise notified by me.

_____________________________________ _________________________

Patient/Parent/Guardian Signature Date

Relationship to Patient: ____ Self ____ Parent ____ Power of Attorney/Legal Guardian