



3500 Barranca Parkway, Suite 325 Irvine CA 92606
PHONE: 949-715-0500 FAX: 855-558-2730

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