Shasta ENT Specialists, Inc.
George H. Domb, M.D.
2125 Court Street
Redding, CA 96001
(530) 242-5600

AUTHORIZATION TO RELEASE INFORMATION

This authorization is not valid if it has not been filled out completely.

Patient's Name: _____ Phone #_____

AKA _____ Date of Birth: _____

Address: _____

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_____ Lab results _____ Radiology reports

_____ Chart notes _____ Insurance information

_____ Hearing test results _____Speech/Language reports/notes

_____ Progress notes from _____ to _____ (dates)

_____ Entire record _____ Other _____

****

Disclosure of information **from**:
(name and complete address)

_____

_____

_____

_____

Disclosure of information **to**:
(name and complete address)

_____

_____

_____

_____

(over)

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to Shasta ENT Specialists. I understand that it will not apply to information that has already been released. I understand that the cancellation will not apply to my insurance company when the law provides my insurer the right to claim under my policy.

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Unless otherwise cancelled, the disclosure of medical information is no longer authorized on _____ (specific expiration date).

When stating date, please allow enough time for processing request.

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I understand that authorization the disclosure of 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 have copied the information to be used or disclosed, as provided in CFR 164-524. I understand that the information disclosed may be redisclosed and that the redisclosure may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Privacy Officer at 242-5600.

I understand that I have the right to receive a copy of this Authorization form. I understand that there may be a fee for the processing of the request.

_____ _____

Signature of Patient or Legal Representative **Printed name** of person signing form

_____

If signed by Legal Representative: **relationship** to patient or description of authority.

_____ _____

Signature of Witness, if applicable **Date** signed

This form complies with requirements of 45CFR164.508(c) and CA Civil Code 56.11