Shasta ent Specialists
Redding sinus Center

George H. Domb, MD
2125 Court Street
Redding, CA 96001
Phone: 530-242-5600
Fax: 530-242-5605

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7 - 10 business days for copying. There is a fee of $25 for copies of Medical Records. The medical records will not be released until this form is completed and signed by the patient or legal guardian and payment is received.

YOU MUST COMPLETE THIS FORM THOROUGHLY.

PLEASE PRINT:

STEP I:

PATIENT NAME: _____ DOB: _____

MAILING ADDRESS: _____
Street City State Zip

STEP II:

I hereby authorize ***Shasta ENT Specialists***

☐ : to release my Medical Records

☐ : to obtain my Medical Records

PHYSICIAN / MEDICAL FACILITY: _____

MAILING ADDRESS: _____
Street City State Zip

CONTACT PHONE #: _____

STEP III:

INFORMATION TO BE RELEASED: DATE (S): _____

☐ Labs ☐ Hearing Test Results ☐ Speech/Language reports/notes

☐ Chart Note ☐ Radiology ☐ Entire Record

REASON: _____

_____

_____

*** THIS MUST BE COMPLETED BEFORE RECORDS WILL BE RELEASED ***

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance to my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to ***Shasta ENT Specialists*** . Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and not protected by Federal Privacy Regulations.

This authorization is valid for 90 days for the release of information as indicated above. **ONLY RECORDS FROM THIS FACILITY CAN LEGALLY BE RELEASED.** Any records from other physicians must be obtained from their office.

_____ _____
Patient / Parent / Legal Guardian Signature: Date:

_____ _____
Witness Signature: Date:

Date Received: _____ Date Copied: _____ Employee:_____