Authorization for Release of Medical Records

1. I hereby authorize _____ to disclose the following information to the California Sinus Centers and Institute from the health records of:

   Patient Name: _____ D.O.B.: _____

   Facility Address: _____ Phone: _____

   Covering the period(s) of healthcare:

   From (date) _____ to (date) _____

2. Information to be disclosed:

   Complete health record(s)
   Inpatient Progress Notes(s)
   Consultation Report
   Operative Report
   Radiology (X-Ray) Reports
   Outpatient/Clinical Notes
   Pathology Report
   History & Physical
   Laboratory Test Reports
   Other (please specify) _____

3. This information will be disclosed to California Sinus Centers. Please mail or fax to:

   ✔ 3351 El Camino Real, Suite 200
   Atherton, CA 94027
   (650) 399-4630 (phone)
   (650) 366-4930 (fax)

   ✔ 2637 Shadelands Drive, Entrance A
   Walnut Creek, CA 94598
   (925) 300-4680 (phone)
   (925) 906-9780 (fax)

   Please transfer requested information by this date: _____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   _____

   Signed: _____ (patient or legal guardian) Date: _____

   If legal guardian, please state relationship to patient: _____