SAN FRANCISCO
OTOLARYNGOLOGY
Providing ear, nose, and throat care since 1940

Authorization for Release of Medical Records

I hereby authorize _____ to disclose the following information to the San Francisco Otolaryngology Medical Group from the health records of:

Patient Name: _____ **DOB**: _____

Covering the period(s) of healthcare: From: _____ To: _____

Information to be disclosed:

- ☐ Complete Health Records(s)
- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Radiology Report(s)
- ☐ Operative Report(s)
- ☐ Audiogram(s)
- ☐ ER/Discharge Report(s)
- ☐ Other (please specify): _____

This information will be disclosed to the San Francisco Otolaryngology Medical Group. Please mail or fax to:

SAN FRANCISCO OTOLARYNGOLOGY MEDICAL GROUP
450 SUTTER ST. SUITE 933
SAN FRANCISCO, CALIFORNIA 94108
PHONE (415) 362-5443 FAX (415) 362-5444

Please transfer requested information by this date: _____

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

SIGNATURE: _____ (patient or guardian) **DATE:** _____

If legal guardian, please state relationship to patient: _____