URGENT – URGENT – URGENT

Santa Barbara ENT
Rebecca D. Golgert, M.D.
2420 Castillo Street, Suite 100
Santa Barbara, CA 93105
Tel: (805) 563-1999 Fax: (805) 563-4999

Authorization for Release of (PHI) Protected Health Information

PATIENT INFORMATION

Patient Name: ____ **Date of Birth (required):** ________________

Last 4 digits of Social Security # (required):_____________ **Alternative identifier:**

REQUESTING RECORDS FROM:

Primary Physician: ______________________________ Physician(s): ____

Organization(s): ________________________________ Organization(s): _____________________________________

Address: ______________________________________ Address: ____

Tel: __________________ Fax: __________________ Tel: ____________________ Fax: ______________________

RECORDS TO BE SENT TO:

Santa Barbara ENT
Rebecca D. Golgert, MD
2420 Castillo Street, Suite 100
Santa Barbara, CA 93105
Tel: (805) 563-1999; **Fax: (805) 563-4999**

Additional Notes/Providers:

DESCRIPTION OF INFORMATION TO BE RELEASED

All health information pertaining to the last three years of my medical history, as well as treatment received. Except for the following (optional): ____

AUTHORIZATION

I hereby grant permission to and authorize the use or disclosure of the above named individual's medical information as described in order to provide continuation of patient care.

Unless otherwise revoked, this Authorization expires ______________(insert applicable date or event). If no date indicated, this Authorization will expire 12 months after the date of signing this form. A copy of this form is as valid as the original.

I understand that I may refuse to sign this authorization and may revoke it at any time in writing to Santa Barbara ENT, 2420 Castillo Street, Suite 100, Santa Barbara, CA 93105. I have a right to review and receive a copy of this authorization.

Signature: ____ **Date:** ______________ Time: ____________

(Signature of Patient/Legal Representative)

Printed Name: _______________________________ Relationship, if signed by representative: __________________

Signature of Witness (if signed by representative)____ Date: _____________