RIVIERA ENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:

DOB:

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND CALIFORNIA LAW, THIS PRACTICE MAY NOT USE OR DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WITHOUT YOUR AUTHROIZATION EXCEPT AS PROVIDED IN OUR PRIVACY POLICAY ACKNOWLEDGEMENT. YOUR COMPLETION OF THIS FORM MEANS THAT YOU ARE GIVING PERMISSION FOR THE USES AND DISCLOSURE DESCRIBED BELOW. IT MAY BE INVALID IF NOT FULLY COMPLETED.

☐ **I AUTHORIZE RIVIERA ENT TO OBTAIN MY MEDICAL RECORDS FROM:**

NAME: _____

ADDRESS: _____

FAX: _____

☐ **I AUTHORIZE RIVIERA ENT TO SEND MY MEDICAL RECORDS TO:**

NAME: _____

ADDRESS: _____

FAX: _____

EFFECT OF REFUSAL TO SIGN AUTHORIZATION:

I UNDERSTAND THAT MY REFUSAL TO SIGN THIS AUTHORIZATION WILL NOT JEAOPARDIZE MY RIGHT TO OBTAIN PRESENT OR FUTURE TREATMENT. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PRACTICE IN WRITING. MY REVOCATION WILL NOT AFFECT ACTIONS TAKEN BY THIS MEDICAL PRACTICE PRIOR TO ITS RECEIPT. THIS AUTHORIZATION IS EFFECTIVE INDEFINITELY UNLESS REVOKED IN WRITING.

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION.

SIGNED: _____ PRINT: _____

DATE: _____

Riviera ENT
1819 State Street, Ste. A
Santa Barbara, CA 93101

(805) EAR-NOSE
(805) 327-6673