Ear Specialty Center

JOHN C. VAUGHAN, M.D.

9850 GENESEE AVENUE, SUITE 650
LA JOLLA, CALIFORNIA 92037
(858) 452-4327
FAX (858) 792-6127
WWW.EARCENTER.COM

OTOLOGY
AUDIOLOGY
NEUROTOLOGY
COCHLEAR IMPLANTS
CHILDREN AND ADULTS
HEARING AID DISPENSING

Authorization Request for Medical Records

The patient medical record contains confidential information which is protected under HIPAA regulations as instituted by the United States Department of Health and Human Services. There are penalties for unauthorized use of this information.

In order to obtain a copy of the medical record, the following forms need to be reviewed and completed. The necessary forms are available on the office website, www.earcenter.com, or can be requested by mail. Also, most medical offices have standard forms which can be used to request a copy of the medical records. Once the forms have been completed, they can be faxed to (858) 792-6127 or mailed to the above address.

The most effective method of providing medical records is to copy the electronic files to a computer compact disk (CD). This will allow the medical facility or health care provider to view the files on their computer and decide what information is needed. It can then be printed for incorporation into the patient's medical record chart, and the disk can then be provided to the individual patient.

In those instances when a CD of the medical records is not possible, paper copies of the medical records can be provided if requested.

For any questions, please contact the office at (858) 452-4327. The office has been closed but messages will be retrieved and answered as soon as possible.

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print in ink ◆ Failure to provide all information may invalidate this authorization.

To Whom:

Send records to:

_____

Individual/Agency Name

_____

Address City State Zip Code Fax #

FACILITY USE ONLY
Requested records have been sent
Date Sent:
By: _____

Information to be released

Dates of Treatment:_____
Office Notes Test Results, type of test _____
Other, Specify _____

Purpose **Reason records are to be disclosed.**

☐ Continued Care ☐ Personal Use (fee applies) ☐ Other, Specify

Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. This authorization shall remain in effect until the above described disclosure is complete but shall not extend beyond 180 days from the date of signature. Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. I have read both pages of this form and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile) of this form for disclosure as described above.

Patient Name (Last, First, MI) _____ SSN _____
Birth Date _____ Phone Number _____
Signature, Patient or Legal Representative _____Date _____
Relationship to Patient (if signed by Legal Representative) _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Important Information Regarding My Rights

Voluntary: I understand authorizing the disclosure of the information identified on Page 1 is voluntary. I need not sign this form to ensure healthcare treatment.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to John C. Vaughan, M.D. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Right to Inspect: I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 and that I have a right to a copy of this form.

Redisclosure: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Questions: If I have questions about disclosure of my health information, I can contact John C. Vaughan, M.D.

Fees: Patient Access (AB610) is charged $0.25 per page, plus postage. All fees with exception of SDI releases will be collected prior to release.