David R. Hantke, M.D., Inc.
P.O Box 1265, Ventura CA 93002
Fax: (888) 641-1948
Email: hantke.records@gmail.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Dr. David R. Hantke, M.D., to disclose the following specific information, only for the purposes and to the parties described below.

Description of the specific information to be used or disclosed:

General medical records

- ○ Operative reports
- ○ Pathology results
- ○ Audiometric results
- ○ Other: _____

Authorized person or entity requesting the information and entitled to make the requested use or disclosure:

_____

Authorized recipient of the information:

_____

Enter address: _____

Destination to which the information should be sent (indicate one of the following and enter desired recipient email/street address or fax number legibly below).

- ○ Email (free) - By selecting this option you acknowledge your understanding that unencrypted email is considered insecure and give us your permission to send your protected health information in this manner nevertheless.
- ○ Encrypted Email (free) - Alternatively, if you email us with the recipient's public encryption key attached (recommended) we will be able to send an encrypted and therefore secure email.
- ○ Fax (free) - Provide number below.
- ○ Mail - $15 charge will be applied and is payable (to David R. Hantke, M.D., Inc.) before mailing.

The information is being requested for the following purpose(s):

_____

This authorization shall remain in effect from the date signed below until:

_____
(please allow enough time for us to actually release the records)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the email address above (on the letterhead).
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by Health Insurance Portability and Accountability Act (HIPAA) regulations.

Patient Name: _____ DOB: _____

Authorized Signature: _____

Relationship to Patient: _____ Date: _____

Note: If you are requesting information pertaining to a person other than yourself or your minor child you will also need to supply proof of your guardianship or other permission to receive or direct the distribution of protected health information.