Mark S. Kita, M.D.
14651 South Bascom Avenue, Suite 240
Los Gatos, CA 95032

Phone: (408) 356-7706
Fax: (408) 356-7736

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Last Name	First	Middle	Social Security Number
Street Address			Birthdate
City	State	Zip Code	Phone Number

THE ABOVE LISTED PATIENT HEREBY AUTHORIZES:

Name of Records Custodian

TO RELEASE THE FOLLOWING RECORDS IN YOUR POSSESSION:

- ☐ **All ENT Records**
- ☐ **Audiograms**
- ☐ **Lab Results**
- ☐ **Radiology Reports**
- ☐ **CT films**
- ☐ **Records relating to**______________________________
- ☐ **Operative Reports**

☐ **Other**____

TO: **MARK S. KITA, M.D.**
14651 SOUTH BASCOM AVE., SUITE 240
LOS GATOS, CA 95032

THE PURPOSE OF THIS DISCLOSURE IS:

☐ **Continuation of Care** ☐ **Referral** ☐ **Other**___________________________

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date of signature.

Patient Signature	Today's Date
Guardian or Parent's Signature if Patient a Minor	

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the use and disclosure described above. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and for the purpose of the disclosure.