HOUSE CLINIC

HEARING, FACIAL NERVE AND BALANCE DISORDERS
NEUROTOLOGICAL AND SKULL BASE SURGERY
COCHLEAR AND AUDITORY BRAINSTEM IMPLANTS
OTOLARYNGIC ALLERGY

OTOLOGY / NEUROTOLOGY
DERALD E. BRACKMANN, M.D.
JOHN W. HOUSE, M.D.
WILLIAM M. LUXFORD, M.D.
M. JENNIFER DEREBERY, M.D.
WILLIAM H. SLATTERY III, M.D.
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NEUROSURGERY
MARC S. SCHWARTZ, M.D.
(213) 353-7067
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(213) 353-7067

MEDICAL OTOLOGY AND OTOLARYNGIC ALLERGY
M. JENNIFER DEREBERY, M.D.

AUDIOLOGY HEARING AID DISPENSARY AND RELATED SERVICES

MAIN OFFICE
2100 West Third Street
First Floor
(At Third and Alvarado)
Los Angeles, California 90057
(213) 483-9930
FAX (213) 484-5900

ORANGE COUNTY OFFICE
1046 Town and Country Road
Building G
Orange, California 92868
(714) 516-9570
FAX (714) 516-9575

HEARING AID DISPENSARIES

SANTA MONICA
(310) 449-1877
FAX (310) 449-1875

HUNTINGTON BEACH
(714) 963-4300
FAX (714) 963-6768

ENCINO
(818) 784-2233
FAX (818) 784-3679

BAKERSFIELD
(661) 322-7280
FAX (661) 322-7438

LOS ANGELES
(213) 353-7052
FAX (213) 207-3223

ORANGE COUNTY
(714) 516-9570
FAX (714) 516-9575

VENTURA
(805) 653-7333
FAX (805) 653-6907

RECORDS RELEASE

Patient's Name : _____

Date of Birth : _____

Address : _____

_____

Phone # : _____

Fax # : _____

I authorize

HOUSE CLINIC
2100 W. Third St, #111
Los Angeles, CA 90057
Fax (213) 989-7408

To disclose to : Dr. _____

Address : _____

_____

The history, findings and treatment pertaining to my medical conditions.

Signature _____ Date _____
Patient, Parent or Guardian

Witness _____ Date _____

If records are more than 15 pages, they will be mailed.

To all patients and physicians offices: *Our office requests a two week advanced notice for photocopying of patients' records*. For patients that are requesting photocopies, there is a fee of $25.00 required before the release of any information.

☐ H.T. ☐ O.P.REPORT ☐ DR'S NOTES ☐ ENTIRE CHART ☐ OTHER

Description : _____

_____