# 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.
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**NEUROSURGERY**
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**OTOLARYNGIC ALLERGY**
M. JENNIFER DEREBERY, M.D.

**VESTIBULAR AND BALANCE DISORDERS**
EDWARD I. CHO, M.D.

**MEDICAL PRACTICE**

- **MAIN OFFICE**
  2100 West Third Street
  First Floor
  (At Third and Alvarado)
  Los Angeles, California 90057
  (213) 483-9930
  FAX (213) 784-5406
- **ORANGE COUNTY OFFICE**
  431 S Batavia Street
  Suite 200
  Orange, California 92868
  (714) 516-9570
  FAX (714) 516-9575

**HEARING AID DISPENSARIES**

- **SANTA MONICA**
  (310) 449-1877
  FAX (310) 449-1875
- **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 to release my records to the following:**

*(If to patient directly please indicate that. Records will be faxed if less than 15 pages, otherwise they will be mailed. We do not email records.)*

Name: _____

Address: _____

_____

Fax: _____

If you wish to request a specific date of service or record please indicate that here otherwise all records in the chart will be provided. We do NOT have copies of imaging studies on disk or electronically. You must request this from the imaging facility.

_____

_____

_____

Signature of Patient or Parent/Guardian: Date:

_____

Witness Date:

**To all patients and physicians' offices**: There is no charge for physician to physician records. For records to be released directly to the patient the charge is $25. Payment can be made via credit card or a check payable to House Clinic. If you wish to make a credit card payment please indicate on the form and we will contact you to process payment. If you are paying by check please submit payment along with the form and mail to House Clinic.

Email forms to us at MedRecs@HouseClinic.com, fax to 213-989-7408 and leave a message at 213-353-7050. Please allow 48 hours for a response.

Please allow 2 weeks for processing of all record requests. We cannot process your request until payment and signed record release has been received.