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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Katherine Chou to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it. I understand I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

Patient name:_____ Date of birth:_____

Patient address:_____ Phone: _____

Person/ Office to receive information:_____

Person/office phone and fax:_____

The specific information to be released/disclosed is specified below:

☐ Complete medical record

Or specify one or more of the following:

☐ Operative report
☐ Progress note
☐ Laboratory
☐ X-rays
☐ Billing and Claim Records
☐ Other-(specify)_____

_____ _____
Signature of patient or patients representative Date

_____ _____
Printed name Relationship