RELEASE OF PATIENT INFORMATION

Natomas Family Practice

Patrick C. Lau, M.D. Steve D. Hwang, D.O.
2410 Del Paso Road
Sacramento, Ca 95834
Ph# (916) 928-0856

MY MEDICAL INFORMATION MAY BE RELEASED OR DISCUSSED WITH THE FOLLOWING PERSON(S) ON MY BEHALF:

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

If any details, please explain:_____
_____
_____
_____
_____

☐ **I DO NOT WISH FOR MY MEDICAL INFORMATION TO BE RELEASED OR DISCUSSED WITH ANYBODY AT THIS TIME.**

EXPIRATION: This authorization is effective immediately and will remain in effect until_____, or for one year from the date of the signature below.

REVOCATION: This authorization is subject revocation by written notice by the undersigned below. Revocation of this authorization will not effect any action taken in reliance to this authorization before receipt of the revocation notice.

REDISCLOSURE: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

SIGNATURE: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents with my direction to the health provider. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the person(s) on this form the protected health information described on this form. I understand that I have the right to receive a copy of this authorization.

SIGNATURE:_____ Date:_____

IF NOT SIGNED BY PATIENT:

NAME OF PERSON SIGNING FOR PATIENT:_____

RELATIONSHIP TO PATIENT:_____