PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS RELEASE REQUEST

PATIENT NAME:_____ **DOB:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

I, _____, AUTHORIZE THE USE AND / OR RELEASE OF MY / OR MY CHILD'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY AND IS MADE TO CONFIRM MY INSTRUCTIONS.

I AUTHORIZE:

NATOMAS FAMILY PRACTICE
PATRICK C. LAU, MD **STEVE D. HWANG, DO**
2410 DEL PASO ROAD
SACRAMENTO, CA 95834
PH# (916) 928-0856 **FAX# (916) 928-1584**

TO RELEASED TO: _____
(NAME OF DISCLOSING PARTY)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP)

_____ _____
(PH#) (FAX#)

HEALTH INFORMATION TO BE DSICLOSED: (PLEASE INITIAL)

_____ ALL MEDICAL RECORDS _____ DRUG / ALCOHOL INFORMATION _____ X-RAY RESULTS

_____ PSYCHIATRIC INFORMATION _____ HIV BLOOD TEST RESULTS _____ BLOOD TEST RESULTS

_____ OTHER (specify):_____

_____

PURPOSE OR NEED FOR DISCLOSURE:_____

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

REVOCATION: This authorization is subject to 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 the contents with my direction to the health provider. I understand that by signing this form, I am confirming my authorization that the health care provider may use and / or disclose to the person / organization mention in this form the protected health information described in this form. I understand that I have the right to receive a copy of this authorization.

SIGNATURE:_____ **DATE:**_____