AUTHORIZATION FORM FOR PATIENT RECORD RELEASE

Section A: Must be completed for all authorizaitons

I hereby authorize the use and disclosure of my individually identifiable health informaton as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipents and may no longer be protected by the Federal privacy regulations.

Patient Name: _____

DOB: _____

Person/Organizations who may Release Patient Records:

Person/Organizations who may receive my information: Please include address and Fax number:

Which Provider do you wish to obtain records from (please select all that apply):

Dr. Joseph Williams MD _____

Dr. Willard Rice MD _____

Dr. Bingjie Ling MD _____

Dr. Dan Liu MD _____

Dr. Kevin Quang OD _____

Dr. Jennifer D'Amico OD _____

Please specify what information you are requesting:
Complete Record or Testing, Notes, Exams please include Dates where necessary:

Section B: The patient or the patient's representative must read and initial the following statements

1. I understand that this authorization will expire on: _____ *Date* *Initial* _____

2. I understand that I will get a copy of this form if I so choose: *Initial* _____

_____ _____

Signature of the patient or patient's representative *Date*

_____

Printed name of patients representative

_____

Relationship to patient