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AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide authorization.

Please **REQUEST** Medical Information **FROM**:

_____
Name of Health Care Provider

_____
Name of Medical Office/Hospital

_____
Street Address

_____
City, State and Zip Code

Please **SEND** Medical Information **TO**:

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Therapist, Attorney)

_____
Street Address

_____
City, State and Zip Code

I hereby authorize_____ to release and/or disclosure the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and/or disclosure records and information regarding:

_____ _____ _____
Name of Patient (List Other Names Used) MRN# Date of Birth

_____ _____
Address City State Zip Code Tel. Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:

Check the box and initial which type of information is to be released and/or disclosed:

☐ **General Medical Information** (from_____ to _____)

☐ **Information Regarding Specific Injury or Treatment** (from_____ to _____)

☐ **X-Ray (check one or both):** **Films** **Reports**

☐ **Laboratory Results**

☐**Mental Health** (from_____ to _____) _____ _____
Signature of Patient or Patient's Representative Date

☐**Alcohol / Drug** (from_____ to _____) _____ _____
Signature of Patient or Patient's Representative Date

☐**HIV Test Results** (from_____ to _____) _____ _____
Signature of Patient or Patient's Representative Date

☐**OTHER (specify):**_____

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

_____

A copy of this authorization is valid as an original.

I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____ _____
Date Signature of Patient or Patient's Representative Indicate Relationship (if Signed by Other than Patient)

Michael J. Wong, M.D., F.A.H.A.
Board Certified in Internal Medicine and Clinical Lipidology
Practice Limited to Cardiology