Authorization to Release Medical Records

Date: ____/____/____

Patient Name: _____Date of Birth: ____/____/____

Patient Address: _____

I, _____ authorize Dr. Vincent D. Ho
TEL: _____ FAX: _____

to release my protected health information to:

INFORMATION TO BE RELEASED

☐Consultation Notes
☐History and Physical Exam
☐Progress Notes
☐Other _____
☐Laboratory Reports
☐Radiology Reports
☐Immunization Records

THE PURPOSE OF THIS RELEASE IS

☐ Continuity of care
☐ At the request of the patient/patient's representative
☐Other _____
☐ Treatment planning
☐ Referral

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____
If no date is indicated, this authorization will expire 12 months after the date signing this form.

PERSONAL USE

I understand I may be charged a convenient fee for copies produced for my personal use. _____
Initial

I understand that I may revoke this authorization at any time by notifying Vincent Ho, M.D. in writing. However, if I choose to do so, my revocation will not affect any actions taken by Vincent Ho M.D. before receiving the revocation.

_____ _____
Printed name of Patient or Patient's Representative Relationship

_____ _____
Signature of Patient or Representative Date

*****A PHOTO ID WILL BE REQUIRED TO PICK UP MEDICAL RECORDS*****