Authorization to Release Medical Records

Date: ____/____/____

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

Patient Address: _____

I, _____ authorize _____

TEL: _____ FAX: _____

to release my protected health information to:

Vincent D. Ho
8843 Valley Blvd.
Rosemead, CA 91770
OR
Fax to 626-287-8861
***For questions or concerns, please contact us at (626)287-8866.*

INFORMATION TO BE RELEASED

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

THE PURPOSE OF THIS RELEASE IS

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

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*****