AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

CHRISTINE CHAI, MD
1441 AVOCADO AVE, SUITE 309
NEWPORT BEACH, CA 92660
(949)631-1333 FAX (949)650-5243

Recipient and Address for Delivery of Records:

Name of Provider: _____

Address of Provider: _____

_____

Phone # of Provider _____

FAX # of Provider: _____

Purpose: I understand that the specific purpose of this Authorization is because

☐ I would like a personal copy
☐ My primary/specialist needs records
☐ I am transferring my care

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

Please specify records to be released or disclosed.

☐ labs	☐ all	☐ most recent
☐ pap smear results	☐ all	☐ most recent
☐ ultrasound report	☐ all	☐ most recent
☐ mammogram report	☐ all	☐ most recent

☐ All of my health information that the provider has in her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information,.

☐ All of my health information described above except for the following:

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.
Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.
Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.
Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____

Patient Name Patient Signature

_____ _____

Date Date of Birth

_____

Witness

If Individual is unable to sign this Authorization, please complete the information below.

_____ _____ _____

Signature of Personal Representative Legal Relationship Date

Name

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.