

AUTHORIZATION FOR RELEASE/EXCHANGE OF HEALTHCARE INFORMATION

Patient Name _____ Date of Birth _____ SS# _____

Address _____

City _____ State _____ Zip _____ Phone number _____

I voluntarily authorize and direct the health care provider named below:

YUJUAN CHOY, M.D.
4199 Campus Drive, Ste 550, Irvine, CA 92612
Phone: (949) 288-3098; Fax: (949) 272-0072

To **release** and/or **exchange** my healthcare information with the recipient identified below:

Name: _____

Address: _____

Phone: _____ Fax: _____

Type of Disclosure: Disclosures may include verbal information, copies of records or letters

Healthcare Information To Be Disclosed: All medical diagnosis and treatment information, including history and physical exams, progress notes, discharge summaries, and laboratory reports. This release additionally authorizes the release of information pertaining to **drug and alcohol abuse diagnosis and treatment** and information pertaining to **mental health diagnosis and treatment**.

Purpose of Release

(please check)

- Continuity of care or for treatment purposes
- At the request of the patient/patient representative
- Other reasons: _____

Notice: Your health care providers are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law.

Expiration of Authorization: This authorization shall remain in effect until _____ (list date or event). If no date/event is indicated, this Authorization will expire one year from date of signing this form.

My Rights: I may revoke this authorization at any time by notifying the provider in writing. The revocation will be effective immediately upon receipt of written notice, except to the extent that my providers have already relied on it before receipt of such revocation. I am entitled to receive a copy of this authorization.

Copies: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Print Name

Signature

Date