AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I voluntarily authorize and direct the health care provider names below to disclose my health information during the term of this Authorization to the recipient that I have identified below:

Dr Catherine Chang
1401 Avocado Avenue, Ste 710
Newport Beach, CA 92660
(949) 717-6755 Fax (949) 717-6859

Recipient and Address for Delivery of Records:
Name of Provider: _____
Address of Provider:_____
_____
Phone number: _____
Fax number: _____

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

- ☐ At the request of the patient
- ☐ Primary care or specialist needs records
- ☐ Transfer of care

  Other _____

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

☐	**Labs**	**all**	**most recent**
☐	**Progress note**	**all**	**most recent**
☐	Xrays	all	most recent
☐	Colonoscopy	most recent	
☐	ECG	all	most recent

- ☐ Last _____ years of records
- ☐ Complete medical record

  Other _____

Please include information relating to (initial if needed):

_____HIV test results _____Substance abuse _____Mental Health _____Genetic test

YOUR RIGHTS:

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Dr Catherine Chang, 1401 Avocado Avenue, Suite 710, Newport Beach, CA 92660.

My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of information).

I may inspect and obtain a copy of the health information that I am authorizing for use of disclosure.

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_____

Expiration: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here:_____

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

Signature of Personal Representative _____Legal relationship_____

Name_____Date_____

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.