Authorization for Release of Medical Record Information

Last name: _____ First name: _____

Home Address: _____ City: _____ State: ____ ZIP: _____

Sex: _____ Age: _____ DOB: _____ Contact Email: _____

Home PH: _____ Cell PH: _____ Work PH: _____

(Father □ Mother □ Self □)

*A Copy Fee May Be Charged For Records

Above listed patient authorizes the following healthcare facility or doctor to make record disclosure:

Facility/Doctor Name: _____ Phone: _____

Address: _____ Email: _____

City/ST/Zip: _____ Fax: _____

Type of information to disclose: [ ] Most Recent Sleep Study [ ] Other: _____

The purpose of disclosure is: [ ] Referral [ ] Other: _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human inmmunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
Please fax or email records to:

Chong Orthodontics
Drs. Leonard and Scott Chong
33800 Alvarado-Niles Rd. Suite #1
Union City, CA 94587
510-489-5671 (main) 510-489-5676 (fax)
www.ChongOrthodontics.com
chongorthodontics1@gmail.com

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked or specified, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient / Parent/ Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship to Patient

_____ _____
Address of Authorized Representative Contact # of Authorized Representative