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AUTHORIZATION to USE/DISCLOSE MEDICAL INFORMATION

1) Patient Name: _____ **2)** Alias/Maiden: _____

3) Date of Birth: _____/_____/_____ **4)** Social Security #: _____-_____-_____

I authorize **Hung D. Tran, M.D.** to:

5) (Initial→) _____ RELEASE INFORMATION TO:
and/or
6) (Initial→) _____ REQUEST INFORMATION FROM:

7) _____
Name of Physician, Clinic, Hospital, Person

8) _____
Address, City, State, Zip Code

9) _____ **10)** _____
Phone Number Fax Number

I authorize the exchange of the following confidential information by my **INITIALS:**

11a) (Initial→) _____ My complete Medical/Mental Health records.

11b) (Initial→) _____ My Medical/Mental Health records for the dates _____/_____/_____ to _____/_____/_____

12) (Initial→) _____ Drug/Alcohol Information

13) (Initial→) _____ HIV tests, results, & related information

14) For the purpose of (check all that apply): ☐ Change of Physician ☐ Medical care ☐ Self use (Fee for this)

☐ Legal Reasons (Please Specify) _____

☐ Other (Please Specify) _____

We cannot condition our provision of services or treatment to you on the receipt of this signed authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. By signing this Authorization, you are directing us to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that we do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

15) _____/_____/_____ **16)** _____
(MM) (DD) (YYYY) Signature of patient or of Representative authorized by law

17) Printed name if signed on behalf of the patient: _____

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