DR. LISA CHANG, DO, FACOG, OBSTETRICS AND GYNECOLOGY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

患者名字: _____ 患者生日: _____

All relant parts are translated on paper for patient response. All other parts are translated verbally in Chinese

This form is used to authorize the release of protected health information in accordance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure/or use of health information about you. Failure to provide all information requested may invalidate this authorization

I hereby authorize Dr. Lisa Chang OBGYN 401 North Garfield Avenue #203 Monterey Park CA 91754 and 1671 South Azusa Avenue Hacienda Heights CA 91745

我要醫療記錄的目的:
[x] 換醫生 [X] 張醫生於 2023 年 8 月 1 日關閉診所

請發送我的全部醫療信息 **TO** (including History and physical, Lab Tests, Radiology Reports that may include: substance abuse, mental health treatment information, Alcohol/drug treatment information, Genetic information/testing, HIV/AIDS/STD related, please cross out information you refuse to release)

[XXX] 我自己 - 我會在 8/1/2023 之前做從報告網站來下載病歷 .
[ ] 我自己 - 每張紙副本為 0.75 美元
[ ] 醫生: _____傳真: _____電子郵件: _____

I hereby authorize the above healthcare provider or facility to release information regarding my medical history, illness or injuries; consultation, prescription, treatments, diagnosis or prognoses; including images, correspondence and/or medical records; by means of mail, fax or other electronic methods. the use and disclosure of protected health information about the patient above

If I had received this health information without consultation, explanation, follow-up as recommended by the doctor, I am fully responsible for my medical condition. I was already given ample opportunity to schedule consultation for such matter and I either 1) am already fully aware of my medical condition or 2) I have refused the consultation.
This authorization will **expire in 90 days** from signature date unless it is revoked by the patient earlier.
Permissions for further use or disclose of this medial information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____ _____ Lisa chang_____
患者簽名 簽名日期 Office Signature with date as beforehand