CHRISTOPHER CHEN, M.D., INC.

Authorization for Release of Health Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

I request and authorize my healthcare information be disclosed by:

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Fax

_____
E-Mail

I request and authorize my healthcare information be disclosed to:

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Fax

_____
E-Mail

Purpose of Disclosure:

☐ Continue Care ☐ Attorney ☐ Insurance ☐ Other (specify) _____

This request and authorization applies to (check box(s), copy fees may apply)

☐ Information from the most recent 2 years of visits

☐ Information from date (you must indicate dates): _____ to date: _____

☐ Specific information (please specify): _____

If applicable: Authorization for Release of Specifically Protected or Privileged Information
I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV/AIDs related information _____ Alcohol & Drug Abuse Records

_____ Psychotherapy (from a psychiatrist, Psychologist, or Mental Health Clinic Nurse Specialist

_____ Other(s): Please List _____

P: (925) 461-2840 | F: (800) 940-9545
www.doctorchrischen.com | contactus@doctorchrischen.com

CHRISTOPHER CHEN, M.D., INC.

I request and authorize that the information be provided in the following format:

☐ Paper Copies ☐ Faxed ☐ Emailed (separate acknowledgement must be signed)

Conditions of Authorization:

This authorization will expire one year from the date signed, or before if noted: _____.
I may revoke this authorization at any time by notifying Christopher Chen, M.D., Inc. in writing, and it will be effective on the date notified except to the extent Christopher Chen, M.D., Inc. has already acted upon such authorization. Information used or disclosed pursuant to this authorization may be subjected by re-disclosure by the recipient and no longer protected by Federal privacy regulations. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, and eligibility for benefits will not be affected. I have been offered a copy of this signed Authorization Form.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records, of my condition to those persons or agencies listed above.

Patient Signature: _____ Date/Time: _____

Print Name: _____

E-MA MAY NOT BE RELIABLE, SECURE, OR PRIVATE. IF YOU WANT YOUR HEALTH INFORMATION TO BE SEND VIA EMAIL, PLEASE READ THE FOLLOWING INFORMATION ON THE RISKS OF RECEIVING EMAIL

RISK OF USING E-MAIL to receive your health records:

- E-mail can be hacked. (Unauthorized people can intercept it, after it, or use it).
- E-mail can be send to the wrong person, lost, or subject to other sending errors.
- E-mail may come from someone other than the names sender.
- E-mail is easier to fake than handwritten, signed papers.
- Anyone with access to an e-mail account will have access to all messages in that account. This includes those who have permission to use the e-mail account as well as those who don't.
- Any deleted e-mails can be found again.
- E-mail services have a right to save and check e-mail sent through their system.
- E-mail can spread viruses.
- You should not receive your health information via email if people who you don't want to view your medical information who have access to your account.

If you are requesting that your information be sent to you or another person by email, you further acknowledge and agree to the risks of transmitting and receiving your information by email, as disclosed in paragraph one of this form, and you agree to release and hold harmless Planned Parenthood from any liability that may result from using e-mail to communicate with you or another person you may have designated to receive emails that include your Health Information. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using e-mail (except as required by law)

_____
Signature Date

Office Staff Only

Type of ID: _____ ID Verified (Circle) Y / N Time of Request: _____

Staff Member who collected request: _____ Date: _____