Authorization for Release of Medical Records

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Mobile Phone #: ( ) _____

Purpose of Release: (☐) Physician, (☐) Patient self, (☐) Attorney, (☐) other: _____

INFORMATION TO BE RELEASED FROM:

TIM K. CHA, M.D., NEUROLOGY MEDICAL CORPORATION
3440 LOMITA BLVD. SUITE #138
TORRANCE, CA 90505
PHONE: (310) 372-2821 WEBSITE: www.timchamd.com

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: ( ) _____ Fax #: ( ) _____

Email Address (Optional if preferred): _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth, consistent with California and Federal laws concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Name of Requestor: _____ Date: _____

Patient's Signature (or responsible party): _____

Phone # of Requestor: ( ) _____

Relationship if other than patient: (☐) Spouse, ( ) Parent, (☐) Child, ( ) Sibling,
( ) Guardian, (☐) other (specify) ☐