Authorization for Use or Disclosure of Health Information

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: ( ) _____ Social Sec. #: _____

Purpose of Release: ( ) Physician ( ) Attorney ( ) Other: _____

INFORMATION TO BE RELEASED FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

INFORMATION TO BE RELEASED TO:

TIM K. CHA, M.D., NEUROLOGY MEDICAL CORPORATION
3440 LOMITA BLVD. SUITE #138
TORRANCE, CA 90505
PHONE: (310) 372-2821 FAX: (310) 372-9358
E-MAIL: timchamd3440@att.net

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.

California law prohibits the requestor from making further disclosure of my health information unless the requestor obtains another authorization from me or unless such

disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address:

My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

This authorization expires on: _____ (or in six months if not specified)

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Name of Requestor: _____ Date: _____

Patient Signature (or responsible party): _____

Phone # of Requestor: ( ) _____

Relationship if other than patient:

( ) Spouse ( ) Parent ( ) Child ( ) Sibling

( ) Guardian ( ) Other (specify) _____