AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTE4CTED HELATH INFORMATION

PACHIE CHAN M.D

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The Woodlands TX, 77385
PH# 936-271-2227
Fax # 936-271-2229

PATIENT NAME: _____ D.O.B._____

LAST FOUR DIGITS OF SOCIAL SECURITY# ____ ____ ____ ____

TEL# _____ FAX # _____

ADDRESS _____

CITY_____STATE _____ ZIP _____

I HEREBY AUTHORIZE PACHIE CHAN M.D. TO

( ) RELEASE (Send Medical Records)
( ) OBTAIN (Receive Medical Records)

( ) TO ( ) FROM: _____ PH# _____

ADDRESS _____ FAX# _____

Select Information Requested

_____ Shot Records _____ Entire Record _____ Radiology Reports

_____ Lab Reports _____ Records From _____ To _____

_____ Other _____

I understand that I may revoke this authorization in writing at any time prior to the release of the information specified above. I hold harmless Dr. Pachie Chan M.D. clinic from liability resulting in the /obtaining of the above information. This authorization expires 90 Days from the signed date.

According to state and federal law you are hereby advised that the information that you authorized for release ,may include: any all test results; diagnostic and or treatment for H.I.V, sexually transmitted diseases, Psychiatric disorders, mental health or drug abuse and or alcohol abuse.

Fee/charges will comply with all laws and regulations applicable to the release information.

I understand that authorizing the use or disclosure of the protected health information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment

SIGNATURE OF PATIENT OR LEGAL REPRESENTIVE: _____ DATE _____

IF REPRESENTATIVE/RELATIONSHIP _____

WITNESS: _____DATE: _____