Gary M. Annunziata, D.O. / Anh T. Duong, M.D.
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Authorization to Release Patient Health Information

FORWARD THIS FORM TO RELEASE OF INFORMATION

Please provide complete and accurate information when submitting this form. Our office will only process valid and complete authorization forms.

PATIENT NAME-_____ **DATE OF BIRTH- _____/_____/_____**

DAYTIME PHONE (_____) _____ **SOC SEC # _____-_____-_____**

I authorize the following physician to release information as stated below from the patient health information record. This authorization covers the time period beginning- ____/____/____ (date) and ending ____/____/____ (date).

INFORMATION TO BE RELEASED *FROM-*	**INFORMATION TO BE RELEASED *TO-***
_____ Organization/ Person Name	_____ Organization/ Person Name
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
(_____)_____ Telephone Number	(_____)_____ Telephone Number
(_____)_____ Fax Number	(_____)_____ Fax Number

TYPE OF RECORDS REQUESTED	
___ Health care information to the following treatment or condition: _____ _____	Sensitive Records requires specific patient authorization. Please initial the appropriate records requested:
___ Laboratory/ Diagnostic Test _____	___ Drug and/or Alcohol Abuse ___ Mental Health (may incl. Pain management or psychiatry)
___ Pathology Report/Slides	
___ Other- _____	___ Sexually Transmitted Disease (incl. AIDS/ HIV)

Purpose or Need for this information- _____ Continuing Care _____ Copies for own use _____ Other- _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Dr. Annunziata/Dr. Duong/ Dr. Lin has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. To revoke an authorization, complete a Revocation of Authorization form, which is available in our office.

I understand that information used to disclose pursuant to this authorization may be disclosed by the receipt and may no longer be protected by federal or state law.

I acknowledge I have fully reviewed and understand the contents of this authorization form, My signature below indicates that I hereby agree and authorize to release of patient health information to the above person or organization.

_____ _____ _____
Date (mo/day/yr) Signature of Patient or Legally Responsible Party Authority to sign, if not Pt.

This authorization is not valid to release future health care more than 90 days from the date signed (except to a payer or as otherwise permitted under law). It will expire in 90 days unless otherwise specified _____ (date/event).