Authorization for release of protected health information (PHI)

Patient Name ____________________ Previous Name (if applicable) ____________________

Date of Birth ____________________

I authorize Alex S. Lin, M.D. to ☐ obtain information from and/or ☐ provide information to

Provider Name ____________________

Address Line and Telephone Number ____________________

- This authorization applies to all health-care information, including
  - ☐ mental-health records
  - ☐ drug-and-alcohol treatment
  - ☐ sexually transmitted disease (STD) results
  - ☐ HIV/AIDS testing, whether negative or positive

- Records are being requested for the following reason: ____________________

- Date(s) of treatment: ____________________

***YOUR RIGHTS**:* Authorization to release information is voluntary. This authorization may be revoked at any time. Revocation must be in writing, signed by you, and delivered to Alex Lin, M.D., at 1800 Fairburn Ave., Ste., 211, Los Angeles, CA 90025. The revocation will take effect when Dr. Lin receives it. You are entitled to receive a copy of this authorization.

NOTICE: Many organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your protected health information (PHI) to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Patient Signature: ____________________ Date Signed: ____________

This authorization expires on ____________________ or 1 year after date signed.