JOHN C. CHIU, M.D.
FAMILY PRACTICE
100 LOS GATOS SARATOGA ROAD, SUITE B
LOS GATOS, CA 95032
OFFICE (408) 863-0709 FAX (408) 863-0245

MRN # ____________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

This authorization for John C. Chiu, M.D. to receive or release information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Section 56 of CA. Civil Code.

PATIENT'S NAME ____
LAST FIRST M.I.

BIRTHDATE ____________________ DAYTIME TELEPHONE NUMBER ____________________
MONTH DAY YEAR

I HEREBY AUTHORIZE:

____
(NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION)

____
STREET ADDRESS

____
CITY STATE ZIP CODE

TO RELEASE INFORMATION AS SPECIFIED BELOW FROM MY MEDICAL RECORD TO:

____
(NAME OF PERSON OR ORGANIZATION REQUESTING INFORMATION)

____
STREET ADDRESS

____
CITY STATE ZIP CODE

THIS RELEASE LIMITS DISCLOSURE TO: (specify time period, dates of treatment, i.e., physical exam, lab reports, x-ray reports)

____

INFORMATION NOT TO BE RELEASED, IF ANY: ____________________________

A specific authorization is required for to release information regarding the following:

Drug/Alcohol Information: ❑ YES ❑ NO Mental Health Information: ❑ YES ❑ NO

THIS INFORMATION IS REQUIRED FOR:

❑ Second Opinion ❑ Referral ❑ Residence Relocation ❑ Insurance Change

❑ Dissatisfaction with Clinic/Department - specify: ____________________________

❑ Dissatisfaction with Physician - specify: ____________________________

❑ Other (please specify): ____________________________

This authorization shall be valid until ____________________ Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only.

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

COPY REQUESTED: ❑ YES ❑ NO COPY RECEIVED: ❑ YES ❑ NO

DATE ____________________ **PATIENT SIGNATURE** ____________________

PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE ____________________

White: Record Copy Yellow: Requestor Copy Pink: Patient Copy