AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ **D.O.B.** _____

Address: _____

Phone #: _____ **SS#** _____-_____-_____

I, _____ hereby authorize:

Facility Name/Provider: _____
Address: _____
City:_____ State: _____Zip:_____
Phone: _____ Fax _____

to release medical records and information pertaining to my medical history to:

Dr. Marchioli/Dr. Kim
15040 Imperial Hwy ***(562)902-1014***
La Mirada , Ca 90638 ***(562)902-1015 Fax***

Please send the following information: (Check ✓)

___All Records
___History & Physical
___Consultations
___Allergy tests, Inj. & Antigen record
___Insurance Information
___X-Ray & Lab Reports
___Progress Notes
___Diagnostic tests
___Other(specify):_____

I hereby authorize the releasing facility to release information as indicated. The releasing facility is herby released from all legal liability that may arise from the release of information requested. I understand that my medical records are protected and cannot be disclosed without my written permission. I also understand that my consent for release is subject to my written revocation. This consent will remain in force from the date signed.

Date:_____ Signature: _____

Date: _____Witness to Signature:_____