AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:

Last Name:	First Name:	Middle Initial:	
Date of Birth:	Social Security:	Home Phone:	Cell Phone:
Address:	City:	State:	Zip Code:

I HEREBY AUTHORIZE THAT MY RECORDS BE RELEASED FROM:

Physician Name/Clinic:	Phone:	Fax:
Address:	City:	State Zip Code

I HEREBY AUTHORIZE THAT MY RECORDS BE RELEASED TO:

Physician Name/Clinic: Beauty Swe, M.D.	Phone: (626) 356-4000	Fax: (626) 799-4001
Address:	City:	State Zip Code
301 South Fair Oaks Ave., Suite 203	Pasadena	CA 91105

INFORMATION REQUESTED (CHECK ALL THAT APPLY):

INFORMATION REQUESTED

(CHECK ALL THAT APPLY):

Dates of Service From: _____
To: _____

❑ Chart Notes ❑ Hospital Summary
❑ Labs ❑ X-Ray reports ❑ Electrocardiogram
❑ Consultation Reports❑ Other:_____

Purpose of Disclosure:
❑ Changing physicians ❑ Referral ❑ Legal
❑ Insurance ❑ Worker's Compensation
❑ Other:_____

I understand that this information may include HIV-related information and/or information related to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information related to:

❑ Substance abuse (including alcohol, drug abuse)
❑ HIV related information (including AIDS related testing)
❑ Mental Health ❑ Psychotherapy Notes

The confidentiality of this record is required under Federal and State laws. By signing below, I specifically authorize the release of above confidential information.

_____ _____
Signature of Patient/Guardian Date

I ❑ do ❑ do not specifically consent to the transmission of medical records via fax with the understanding that the confidentiality at the receiving end cannot always be guaranteed.

- I understand that I may revoke this authorization any time by notifying, Beauty Swe, M.D., Privacy Officer, at 630 Mission Street, Suite A, South Pasadena, CA 91030, in writing and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that a photocopy of this form will be considered as valid as the original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ _____
Signature of Patient/Parent/Guardian Relationship to Patient Date