AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize ____ to release the protected information of :

Patient Name: ____

Date of Birth: _____________________________ SSN: ______________________________

Address: ____

Phone Number: ____

To: Name of Recipient: ____

Address: ____

Information to be disclosed: Dates of Service: ____________________ _____ Entire Medical Record _____ Medical Bills _____ Other: Please specify: _________________________________	Purposes of Use and/or Disclosure: _____ Legal Purposes _____ At the request of the patient _____ Other: _________________________________

_________ (Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed).

***Unless otherwise revoked, this authorization will expire on the following date or event:________ . If a date or event is not specified, this authorization will expire one year from my date of signature below.**

A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Dr. Jeong H. Kim, MD, PLLC will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by notifying Dr. Jeong H. Kim, MD, PLLC in writing of my revocation. I understand that the revocation will not apply to any information that already was released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself..

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Dr. Jeong Kim, MD, PLLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or any professional opinions, findings, or recommendations as contained in the records released pursuant to this authorization.

Requestor's Signature: ____

Patient/Legally Authorized Representative

Printed Name: ____Date:__________________

Relationship to Patient (if requestor is not patient): ___________________________________