Print Form

Medical Records Release Authorization

ATTENTION:

Physician or Hospital

Address

City | State | Zip

( ) | ( )

Telephone # | Fax #

I hereby authorize and request you to release to:

William J. Tsai, M.D., Inc.
19742 MacArthur Blvd, Ste. 101 <> Irvine, CA 92612
949-955-0202 Phone <> 949-955-0203 Fax

Information to be released:

☐ ALL records ☐ Lab results ☐ Medication List
☐ Progress Notes ☐ Imaging ☐ Consults

Purpose for which disclosure is being made:

☐ Insurance ☒ Physician
☐ Attorney ☐ Personal

Please PRINT:

Patient Name

/ / | XXX - XX - ____ ____ ____ ____

Date of Birth | SSN (last 4 digits)

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment.

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. A copy of this authorization is as valid as the original.

Signature: _____ Date: / /

(Patient, Guardian* or Authorized Representative*)

*Please provide documents to prove authority to sign on behalf of the patient.

~~~~~~~~~~~~**This authorization will expire 180 days from the date signed.**~~~~~~~~~~~~
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