TRUONG DUONG, M.D.

AUTHORIZATION TO USE/DISCLOSE (RELEASE) HEALTH INFORMATION

PATIENT IDENTIFYING INFORMATION

Patient's Name_____

Date of Birth_____ Social Security Number_____

THIS IS TO REQUEST AND AUTHORIZE:_____

RELEASE RECORDS TO

Name/Organization_____Phone Number_____

Address_____ City_____ State_____ Zip Code_____

Purpose(s) of Disclosure_____

(Including any limitations on use or disclosure)_____

INFORMATION TO BE RELEASED

_____ Medical Records
_____ Labs
_____ Other(Describe)_____

Specify Dates of Treatment_____

YOUR RIGHTS

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to Dr. Duong's office at 4500 Brockton Ave. Suite 319 Riverside, CA. 92501 My revocation will be effective upon receipt, but will not be effective to the extent that Dr. Duong or others have acted in reliance upon this authorization. It is possible that the information disclosed under this Authorization could be subject to redisclosure by the recipient and no longer protected by federal or state privacy laws. I have a right to receive a copy of this Authorization. I acknowledge that his Authorization was filled out completely at the time of my signing. I understand that there may be circumstances that would allow Dr. Duong to receive a fee in exchange for disclosing the information requested on this Authorization.

SIGNATURE

Signature of Patient/Legal Representative_____

Date_____

Relationship of Patient/Authority to Act for Patient_____

Witness_____ Authorization Duration_ _____

This Authorization shall become effective immediately and shall remain in effect per dated above or for six months from the date of signature if not date entered.

PLEASE FAX RECORDS TO (877) 773-8640 or CONTACT OUR OFFICE AT (877)773-8664