Dr. Steven Kim, M.D.
Khine Hlaing, F.N.P.
Pou Lue, F.N.P.
Elsie Szeto, MS, RD

Authorization to Release Protected Health Information

All sections must be completed for authorization to be valid.

Part I - Patient Information

Last Name:	First Name:	Middle:
Date of Birth:	Phone number:	
Address:		
Street	City/State/Zip Code	

Part II - Individual/Organization Authorized to Release PHI

Name:	
Address:	
Street	City/State/Zip Code

Part III - Individual/Organization Authorized by Signatory to Receive PHI

Name:	
Relationship to Patient:	Phone**:**
Address:	
Street	City/State/Zip Code

Part IV - Authorization Expiration Event or Date

Unless otherwise revoked by the patient, this authorization for the release of PHI to the above-named individual/organization will expire on the event of date specified below, or 12 months from the date in Part VIII.

Expiration Event:	Expiration Date:

Part V - Health Records to be Released - General

I authorized the following records to be released:

☐ Medical Records (Full)	☐ Dental Records	☐ Other
☐ If Other, please specify:		

Part VI - Purpose for the Release or Use of the Information

☐ Health Care	☐ Personal	☐ Legal
☐ Other (please specify):		

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Part VII - Authorization Information

I understand the following:

1. I authorize the use or disclosure of the health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part II. The revocation will prevent further release of my health information from the date of receipt.

3. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.

4. The party entered in Part III is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).

5. If the party entered in Part III is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.

6. I have a right to receive a copy of this authorization.

7. Fees may be charged to cover the cost of releasing the health information.

8. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Part VIII - Signature by or on Behalf of Patient

Name of Patient (Print):	
Signature:	Date:
Name of person signing form (if not patient)**:**	
Authority to sign on behalf of patient:	
Name of Translator (*if applicable*)	
Signature of Translator (*if applicable*):	