# *Authorization for Use and Disclosure of Protected Health Information*

*(PHI) Patient Legal Name: _____*

*Date of Birth: _____*

*I hereby authorize (Dr's Name) _____ @ (fax number) _____ to disclose medical record information and/or protected health information of the patient listed above to:*

*Richard P Chern, MD LLC*

*12889 Hwy 98 West Miramar Beach, FL 32550*

*Phone: 850.837.1271*
*Fax:*

*Type of Access Requested (check below or specify): _____*

*____ All Medical Records*

*____ Laboratory Records*
*____ Imaging/Radiology*
*____ Emergency Room Records*

*____ Medication Record ____ Physician Orders ____ H&P ____ Rehab Services*

*____ Consultation Report*
*____ Operative Report*

*_____(Initial) I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.*

*I understand that my right to healthcare treatment is not conditioned on this authorization.*

*I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.*

*If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.*

*I have read the above and authorize the disclosure of the protected health information as stated.*

_____ _____

*Date* *Signature of Patient/Parent/Guardian*