

HEALTH INFORMATION RELEASE FORM

This form represents your consent and authorization for the parties below to use, disclose, and receive medical and mental health information pertaining to yourself.

I, (PRINT PATIENT NAME) _____, hereby authorize Donovan Wong, MD to disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about my diagnosis and treatment for the following purposes: to increase understanding of my previous history, diagnosis and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with family, friends or others that may be important sources of support.

Information is to be disclosed to and/or received from the following parties:

INDIVIDUAL OR ORGANIZATION	ADDRESS	PHONE AND FAX NUMBER
1.		
2.		
3.		
4.		

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Donovan Wong, MD to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation. I understand that I have the right to refuse consent and signing of this authorization. I understand that I am voluntarily signing this form to release my health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.

SIGNATURE _____ **Date** _____