

Authorization for Release of Medical Records

Practice Information

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Authorization

This release authorizes: (Name/Address of Health Care Provider)

to release to [Medical Practice] the information specified below from the medical records maintained when I was treated in the above facility.

_____ Doctors' Notes

_____ Lab Reports

_____ All

Signature

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire in one year following the date of signature. Please Send or fax medical records to the address listed above.

Patient Name _____

DOB / / _____

Signature _____

Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.