AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: Any and All Treating Health Care Practitioners or Facilities

This document authorizes any and all licensed health care facilities, including but not limited to: Medical Transport Services, hospitals, clinics, laboratories, pharmacies, medical Spas, diagnostic imaging, blood establishments, facilities and blood bank who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Health Regulation Authority (or any official representative of the Authority) pursuant to the Health Regulation Authority Ordinance and Regulations.

This document provides full authorization to the Health Regulation Authority (or any official representative of the Authority) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Authority and may be subject to re-disclosure by the recipient.

By signing below, the patient understands, acknowledges and authorizes the Health Regulation Authority to release their identity and medical records to enforcement and other regulatory agencies in appropriate circumstances at the Authority's discretion.

A photocopy of this document is as sufficient as the original.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print):_____
First Last Middle Initial

D.O.B.:_____ ID Type: _____ ID No.:_____
Day Month Year

Signature: _____ Date:_____
Day Month Year

Name of Authorized Person: _____
First Last Middle Initial

ID Type: _____ ID No.:_____

Signature: _____ Date:_____
Day Month Year

Name of Witness: _____
First Last Middle Initial

ID Type: _____ ID No.:_____

Signature: _____ Date:_____
Day Month Year