ANH LEE, MD
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

I hereby authorize, **Dr. Anh Lee** to distribute the records listed below for Release of Protected Health Information.

____
Name of Doctor, Hospital, Person, Institute, Agency or Self

____
Street Address **City** **State** **Zip Code**

Phone Number: ____________________ **Fax Number:** _____________________

___ **Entire Medical Record**
___ **Operative Report**
___ **Laboratory/Pathology Reports**
___ **Radiology Reports**
___ **Breast Cancer Related Information**
___ **Substance Abuse/Dependency**
___ **Psychiatric/Mental Health Treatment**
___ **HIV/AIDS Information**
___ **Sexually Transmitted Disease Test/Treatment**
___ **Other** _________________________

___ **DO NOT** release any medical information to the following:
____

Patient Name: __________________________________ **DOB:** _______ **SSN:** _______________
Patient Signature: ____ **Date:** ________________
PERSON REQUESTING MEDICAL RECORDS OTHER THAN PATIENT
Signature: ________________________ **Relationship to Patient:** ____________ **Date:** ____________

This consent is effective from the date listed and will expire one year from the date signed. I understand that I may revoke this authorization, in writing, at any time, except to the extent that disclosure was made prior to the time I revoked this authorization. I understand that the health records/information used or disclosed, may be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I understand that providing my authorization is voluntary. I further understand that my records may be protected under state law and if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations. My signature acknowledges that I have read, understand, and authorize the release of information above.

Transmission by facsimile or electronic means is authorized to expedite transfer of records.

If you are transferring to your care to another provider, please check appropriate box:

□ **Moving out of town** □ **Dissatisfied** □ **Personal Use** ***fee applies***
□ **Other, please explain** __________________

Adopted: 10/2015
Revised: 1/2020