AUTHORIZATION FOR USE OR DISCLOSURE
OF
MEDICAL INFORMATION

Patient Name: ________________________________ D.O.B. __________

Address: ____

Phone #: ________________________ SS# ______-_____-______

I, ____hereby authorize

Dr. Marchioli/Dr. Kim
15040 Imperial Hwy.
La Mirada, CA 90638

(562) 902-1014
(562) 902-1015 fax

To release medical information to:

Facility Name/Provider: ____

Address: ____

City:______________________ State: __________Zip:_____________________

Phone: ______________________ Fax ________________________________

Please send the following information:

___All Records
___History & Physical
___Consultations
___Allergy tests, Inj. & Antigen record
___Insurance Information
___X-Ray & Lab Reports
___Progress Notes
___Diagnostic tests
___Other (specify):_________________________

I hereby authorize the releasing facility to release information as indicated. The releasing facility is herby released from all legal liability that may arise from the release of information requested. I understand that my medical records are protected and cannot be disclosed without my written permission. I also understand that my consent for release is subject to my written revocation. This consent will remain in force from the date signed. Please inquire with medical record department to ascertain if a COPY FEE will be charged.

Date:____________________ Signature: ______________________________

Date: ____________________Witness to Signature:______________________