REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM: ____
Name of Physician, Hospital or Facility

ADDRESS: ____

____

Phone: (______) _________ - ________________

Fax: (______) _________ - ________________

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

CHRISTINE CHAI, MD
901 DOVER DRIVE, SUITE 214
NEWPORT BEACH, CA 92660
(949) 631-1333
FAX #: (949) 650-5243

This authorization releases my medical records for the following designated purpose:

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I understand that I am entitled to receive a copy of this release.

______________________ ______________________
Patient Name **Patient Signature**

______________________ ______________________
Date Signed **Date of BIrth**

______________________ ______________________
Print Name of Legal Guardian (relationship), if applicable **Witness**

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.