



Harrison Hasanuddin, DO

張宏彬 醫學博士

MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize the disclosure of my protected health information:

Organization/Name : _____

Address : _____

City, State, Zip : _____

Phone Number : _____

Fax Number : _____

To release to:

Harrison Hasanuddin, D.O., Inc.

420 North Garfield Avenue, STE 203

Monterey Park, CA, 91754

Phone: 626-763-1899 Fax: 626-547-4438

I authorize _____ ("Authorized Party") to use or disclose the following:

All Health Information

X-Ray Report(s) : _____ Date(s): _____

Pharmacy Report(s) : _____ Date(s): _____

Lab Report(s) : _____ Date(s): _____

Other : _____

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

I understand that I may withdraw this authorization in writing at any time.

Signature: _____ Date: _____

I am the patient's Legal Guardian. Full name: _____

OFFICE USE

REV'D BY _____