AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ____ DOB: ______________________

Previous Name:____ S.S.# _______________________

To:____
____
____
Phone: ____ Fax:_____________________________

I hereby authorize and direct the healthcare provider named below to disclose my health information to the recipient I have identified above.

Patricia Korber, M.D.

351 Hospital Road, Suite 611, Newport Beach, CA 92663
Phone: 949-423-7384 Fax: 949-423-7388
(only fax records if under 10 pages)

Information to be disclosed: This authorization permits the above named healthcare provider to disclose the following medical records:

□ Only the following records or type of healthcare information: (enter dates or year on line)

□ _______ Pap Smear (s) □ _______ Mammogram (s)
□ _______ Lab Test (s) □ _______ Radiology Report (s)
□ _______ Operative Report (s) □ _______ Pathology Reports (s)
□ _______ Other____

□ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical conditions and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and information, correspondence, and records from my other healthcare providers that the above named provider may hold.

□ All of my health information described above except for the following:
____
____

______________________________ _______________ ________________________________
Patient Signature Date Signature of Witness

If individual is unable to sign this authorization, please complete the information below:

_________________________ _______________ _______________ ________________________________
Signature of Personal Representative Legal Relationship Date Signature of Witness

Name of Personal Representative: ____
(Please Print)