HANH N. HOANG, MD
Obstetrics & Gynecology

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name	Other name(s) used	DOB	
Address	City	State	Zip

I hereby authorize _____ to release protected health information of the above named to

Dr. Hanh Hoang
210 N. Jackson Ave, Ste 10 Phone (408) 258-7000
San Jose, CA 95116 Fax (408) 228-3751

INFORMATION TO BE RELEASED

☐ Hospital and Emergency Records ☐ Consultations ☐ Radiology Reports
☐ Clinic Reports ☐ Laboratory Reports ☐ Immunization Records
☐ Operative Reports ☐ Pathology Reports ☐ Other _____

Specify the date or time period for information selected above: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
☐ I specifically authorize the release of HIV/AIDS testing information.
☐ I specifically authorize the release of genetic testing information.

THE PURPOSE OF THIS RELEASE IS *(check one or more)*
☐ Changing physicians ☐ At the request of the patient/patient representative
☐ Consultation ☐ Other (state reason) _____

NOTICE

Organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Dr. Hanh Hoang. The revocation will take effect upon receipt, except to the extent that Dr. Hanh Hoang or others have already relied upon it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Name of Legal Guardian, if applicable (please print) Relationship to Patient