General Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- ☐ ☐ All records
- ☐ ☐ Laboratory/pathology records
- ☐ ☐ X-ray/radiology records
- ☐ ☐ Billing records
- ☐ ☐ Abstract/Summary
- ☐ ☐ Pharmacy/prescription records
- ☐ ☐ Other (describe specifically)

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Dr. Gabriel Chiu
Beverly Hills Plastic Surgery, A Medical Corporation
9454 Wilshire Boulevard Ground Floor
Beverly Hills, California 90212
310-888-8087 MAIN
310-861-1160 FAX
gchiu@bhpsinc.com

The information may be used/disclosed for each of the following purposes:

- ☐ ☐ At my request (only the patient can check this box)
- ☐ ☐ For my health care
- ☐ ☐ For payment/insurance
- ☐ ☐ For employment purposes
- ☐ ☐ Other:

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for California medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's representative Date