Loanne B. Tran, M.D., M.P.H. & T.M.

Internal Medicine & Pediatrics
624 W. Duarte Road. #205
Arcadia, CA 91007
Phone: 626.446.0810 Fax: 626.254.9879

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Date of Birth

_____

I request and authorize:

Name of Hospital/Provider: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ **Fax**: _____

To release healthcare information of the patient named above to: **Loanne B. Tran M.D., 624 W. Duarte Road, #205, Arcadia, CA 91007 , Fax 626-254-9879**

This request and authorization applies to:

☐ Entire File

Records from specific date:

From _____ **To** _____

Specific lab/X-ray report:

_____

I, the undersigned, being (check one)

- [ ] The above-named patient
- [ ] The legal representative of the above-named minor or incompetent patient
- [ ] The spouse (only where the information authorized for release is sought for the sole purpose of processing an application for health insurance or enrollment in a nonprofit hospital plan health care service plan or employee benefit plan and the patient is to be an enrolled spouse or dependent there under).
- [ ] The beneficiary or person representative of the above-named patient who is deceased (please provide such documentation).

Signature

Date

_____

I hereby further authorize the release of the following information which is protected under the California Welfare and Institution Code, Section 5328.

Choose all that apply

- [ ] Psychiatric Records
- [ ] Substance Abuse
- [ ] HIV/AIDS

Signature

Date

_____

Please note, our office will be glad to make a courtesy copy of your record to another physician's office. However, we charge a fee of $20, to make a copy of your health record for personal use.

THIS AUTHORIZATION SHALL BE EFFECTIVE IMMEDIATELY AND REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.