Barbara K. Chen, MD, FACOG
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize the release of healthcare information to Barbara K. Chen, MD from

Physician or Hospital Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.