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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ DOB:_____

I hereby authorize Dr. Yung Chen, M.D. to disclose my medical records to:

Name of Person/Organization: _____

Phone: _____

Fax: _____

Dates of records requested from _____ to _____.

Type of records requested (mark all that apply):

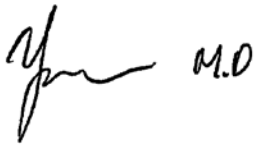
- ☐ **Clinical/procedural notes**
- ☐ **Radiology reports**
- ☐ **Billing record**

I would like my records to be (choose one):

- ☐ **Printed**
- ☐ **Faxed**
- ☐ **Converted to PDF for USB**

There may be a fee for the records, which will be determined by the volume of your file. Please allow up to two full business weeks for request to be completed.

Date: _____ Signature: _____



Yung Chen, MD
Lic#: A054788