PACIFIC SHORES MEDICAL GROUP
Member, UCLA affiliated Translational Research Network
Comprehensive Hematology/Oncology Services
www.pacshoresoncology.com

AUTHORIZATION FOR RELEASE OF INFORMATION

To:____
(Name/Address & Facility)
____

I, _________________________________ DOB: __________ MRN: ___________
hereby authorize the release of the following:

[ ] History & Physical | [ ] Pathology Reports | [ ] Progress Notes
[ ] Surgical Reports | [ ] Diagnostic (X-Rays, Scans etc.) | [ ] Lab Results
[ ] Consultation Reports | [ ] Nursing Assessments | [ ] All the above

Other ____

for care received from: ____________________________ to: ______________________________

for the specific illness or injury of: ____

To Pacific Shores Medical Group:

[ ] N. Simon Tchekmedyian, MD
[ ] Lihong Wu MD
[ ] Sassan Farjami, MD
[ ] Eleonor Quan, MD
[ ] Kalust Ucar, MD
[ ] David M. Burtzo, MD
[ ] André K.D. Liem, MD
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The purpose of this released information is continuity of care. Exchange of information ensures continuity of care between providers, and without such exchange my healthcare may be compromised. I understand specific reference may be made to psychiatric conditions, HIV testing and results, and any related diagnosis and medical condition(s) which may be recorded in my health records. I hereby authorize the release of such information.

I understand that the information released/exchanged will be treated in a confidential manner and will not be released to other persons or agencies without my specific authorization. This authorization expires a year from the date of my signature. I understand I have the right to revoke this consent at any time in writing except to the extent that information has already been released.

_________________________________ ____
(Signature witness) (Date) (Signature of Patient/Guardian) (Date)

____
(Relation to Patient)