



Hematology · Oncology · Infusion Services
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Danny Nguyen, MD • Eleonor T. Quan, MD • Sarmen Sarkissian, MD • N. Simon Tchekmedyian, MD • Nishan Tchekmedyian, MD • Kalust Ucar, MD • Lihong Wu, MD

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 [] Kalust Ucar, MD [] Mojtaba Akhtari, MD [] Lihong Wu MD
[] Mohamad Barakat, MD [] Luke Chen, MD [] Sassan Farjami, MD [] André K.D. Liem, MD
[] Mark M. Ngo, MD [] Eleonor Quan, MD [] Danny Nguyen, MD [] Nishan Tchekmedyian, MD [] Dilruba Haque, 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)