Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Authorization to Request Protected Health Information From Other Healthcare Provider

Patient Name: _____ Telephone number: _____

Date of birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. I authorize the following organization to make this disclosure:

   Name: _____

   Address: _____

   _____

   _____

   Fax Number: _____ Phone Number: _____

3. The type of information requested is the entire record except the following listed items:

   _____

   _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
   I wish to ☐ include ☐ exclude this information in my disclosure.

5. The information identified above is to be disclosed to **Dr. Wilbur Kuo & Associates Internal Medicine, LLC, 5963 Exchange Drive Suite 112, Sykesville, MD 21784. Phone number: 410-552-8126. Fax Number: 443-458-7220. E-mail: drkuomd@gmail.com Direct e-mail: wkuo@drkuomd.amazing-direct.com**

6. This information for which I'm authorizing disclosure will be used for the purpose of medical treatment of the above named patient by Dr. Wilbur Kuo & Associates Internal Medicine, LLC.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Office Manager of Dr Wilbur Kuo & Associates Internal Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. Unless I specify differently, this authorization will expire on: _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____