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CONSENT TO RELEASE MEDICAL RECORDS

I hereby authorize and request that ____
Name of the physician

____
Physician's Address City/State/Zip

________________________________and ___________________________________
Physician's Phone Number Physician's FAX number

to release the following information from my medical records to my primary care physician Dr. Guo at the address shown above.

Information to be released:

Diagnosis and record of treatment

Laboratory and/or X-ray reports

Entire file (excluding confidential and psychiatric records, if any)

Other____

I understand that upon my request, I will be given a copy of the information released. I also understand that there will be a small processing fee for the copy I personally receive. I give my consent to the release of aforementioned information and understand that my consent is subject to revocation at any time. I further understand that this consent will expire 60 days after the date of the signature.

Patient name_____________________ SSN______________________ DOB _______________

Patient Signature________________________Date__________________________