AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize Dr. Ryan Walters of 123 HealthCare City

(Name and address of facility/health care provider you wish to release information)

To release information requested for (either DOB or SID is REQUIRED to identify record):

Hanni Chiong **D.O.B** January 26, 1990 **S.I.D** 123-45-678

(Name of person making request) (Date of Birth)

To: Lester Chiong
Letty Vasquez

For the purpose of: Access to health information
For insurance and billing

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

_____ All hospital records (including nursing records and progress notes)

_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five year history
_____ Laboratory reports
_____ Emergency and Urgency care records

_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician Office Chart notes
_____ Laboratory reports

_____ Other (explain below)
_____
_____

Hanni Chiong Please send the entire medical records (All information) to the above named recipient

I authorize the information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

_____ *HIV/AIDS - related records (Copies will not be released to inmates while incarcerated)

_____ *Genetic testing information

_____ * Mental Health-list specific info requested _____

Hanni Chiong **Alcohol and Drug information

**PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

** Must be initialed to be included in other documents. Records will not be released without your initials specifying that you have granted this specific release authority.*

This authorization is limited to the following time period: August 2023 - December 2023

This authorization is limited to a worker's compensation claim injuries of: second-degree burns on both hands and a dislocated left shoulder, sustained on July 15th, 2023

My signature indicates that I authorize the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

Hanni Chiong — August 18, 2023

(Signature of Patient) (Date)

Lester Chiong — August 18, 2023

(Signature of legal/personal representative authorized by law) (Date)