THANG NGUYEN, MD
Family Physician
328 N. San Mateo Dr., Suite A
San Mateo, CA 94401
Tel: (650) 260-5225
Fax: (888) 939-4131

Patient's Name: _____
MR No: _____
Date of Birth: _____
Age: _____ Sex: M ____ F _____
Phone: (H) _____
(W) _____

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION (Please Print Must be completed in ink)

Patient Name: _____ Social Security Number: _____
Date of Birth: _____ Phone number : _____
Address: _____ City: _____State: ____ Zip Code: _____

RELEASE MY HEALTHCARE INFORMATION FROM:

Name of Facility/Provider: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

SEND MY HEALTHCARE INFORMATION TO:

Name of Facility/Provider: Thang Nguyen, MD
Address: 328 N. San Mateo Drive, Suite A
City: San Mateo State: CA Zip Code: 94401
Phone Number: (650) 260-5225 Fax Number: **(888) 939-4131**

INFORMATION TO BE RELEASED

☐ All medical records
☐ Most recent 2 years or pertinent information:
- ☐ Clinic Visits (specify) _____
- ☐ Gynecologic Exams (including PAP)
- ☐ Laboratory Results Only (specify) _____
- ☐ X-Ray Films – (charge for copies)
- ☐ Immunization
- ☐ HIV Test Result(s) _____ (initials)
- ☐ X-ray Reports Only (specify) _____
- ☐ Other Information (specify) _____

REASON/PURPOSE FOR RELEASE OF INFORMATION

☐ Change of Insurance ☐ Transfer of Care ☐ Legal Investigation
☐ Insurance Reimbursement ☐ Moving Out of Area ☐ Personal Use
☐ Specialist Consultation ☐ Other: _____

PATIENT AUTHORIZATION

This information is intended for use by the above named recipient only. I understand that the information in my health record may include information relating to psychiatric or psychological testing, physical abuse, drug and alcohol abuse, sexually transmitted disease, human immunodeficiency virus (HIV) testing and/or status, or acquired immunodeficiency syndrome (AIDS).

PATIENT RIGHTS

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. This authorization will expire exactly one year from the date below or on _____. I have the right to receive a copy of this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient without being further protected under the HIPAA rules.

I understand that I may be charged for copies provided. Initials _____

Signature of Patient: _____ Date: _____
(Guardian or authorized representative must provide appropriate documents before signing on behalf of the patient)
Witnessed by: _____ Date: _____

NOTE: PLEASE ALLOW 15 DAYS FOR PROCESSING. INCOMPLETE INFORMATION WILL DELAY PROCESSING.