AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Version 1, revised 9/5/2026

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

1. Please REQUEST Medical Information FROM:

NAME OF HEALTH CARE PROVIDER: _____

NAME OF MEDICAL OFFICE/HOSPITAL: _____

PHONE/FAX/EMAIL: _____

CITY, STATE AND ZIP CODE: _____

2. Please SEND Medical Information TO:

NAME: Karin Li MD

ADDRESS: 13768 Roswell Ave Suite 215

CITY, STATE, ZIP: Chino, CA 91710

TEL: 909-325-2215

FAX: 888-491-0615

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

3. Release and/or disclose records and information regarding:

NAME OF PATIENT: _____ **MRN:** _____

ADDRESS: _____ **DOB:** _____

CITY, STATE, ZIP: _____ **TEL:** _____

4. SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

Check the box and initial which type of information is to be released and/or disclosed:

[ ] Initial: _____ **General Medical Information** (from _____ to _____)

[ ] Initial: _____ **Information Regarding Specific Injury or Treatment** (from _____ to _____)

[ ] Initial: _____ **X-Ray** [ ] Films [ ] Reports

[ ] Initial: _____ **Laboratory Results**

[ ] Initial: _____ **Mental Health** (from _____ to _____)
Signature: _____ Date: _____

[ ] Initial: _____ **HIV Test Results** (from _____ to _____)
Signature: _____ Date: _____

[ ] Initial: _____ **Alcohol/Drug** (from _____ to _____)
Signature: _____ Date: _____

[ ] Initial: _____ **Other (specify):** _____

PURPOSE: I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only:

_____

5. DURATION, REVOCATION, AND REDISCLOSURE TERMS:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

• A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

DATE: _____

SIGNATURE OF PATIENT OR REPRESENTATIVE: _____