AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE

Physician Name: _____

Street Address: _____ _____

City, State Zip: _____

Phone Number: _____ Fax number: _____

To furnish a copy of the information requested below. Upon making this request, I hereby release you and your employees from any liability for following this authorization. This authorization is valid for 12 months from the date of signature. Any change in authorization must be in writing.

INFORMATION NEEDED:

[ ] All records [ ] X-ray reports [ ] Operative report

[ ] Hospital stay [ ] Hospital discharge summary [ ] Other

Reason for release of medical information: _____
_____

Patient name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City, State, ZIP: _____ Phone number: _____

Patient/Guardian signature: _____

PLEASE SEND RECORDS TO:

Charles Hsu, M.D.

4610 Sweetwater Blvd. #220
Sugar Land, TX 77479
Phone: 281-242-1127
Fax: 281-242-7478 [CHAS.HSU]

For Office Use Only:

Date Requested _____ Requested By _____