HIPAA MEDICAL RECORDS RELEASE INFORMATION

Records From:

KYI KYI THWIN WIN MD INC

P.O.BOX 2229

29099 HOSPITAL ROAD #107

LAKE ARROWHEAD, CA 92352

Fax: **(909) 485-1847**

Records To:

NAME: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby authorize the physician and/or employees of **Kyi Kyi Thwin Win M.D. Inc** to release medical information as indicated below.

Records Regarding:

Last Name: _____ First Name: _____

Birth Date: _____ Phone: _____

Address: _____

City: _____ Zip: _____

Email address: _____

Please print clearly

Duration: This authorization shell become effective immediately and shall remain in effect until _____ {enter date} or for one year from the date signature.

Revocation: This authorization is also subject to written revocation by undersigned at anytime between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not effective to the extent that the requester or others have acted in reliance upon this authorization.

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 a copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

Patient Signature: _____ **Date:** _____

Relationship if other than patient: _____

Effective 5/15/19: Medical record copy fee: **$25** administration fee plus 0.25 cents per page. **You will receive invoice via** **Email** ☐ **US mail** ☐
Records will be released **after payment received**. Allow 15 days turn around.

Please see California Law regarding medical records and copying fees:

www.mbc.ca.gov/Consumers/Access_Records.aspx