Benjamin N. Wan, MD, INC
595 Buckingham Way, Suite 500
San Francisco, CA 94132
Tel 415.665.6100 Fax 415.665.6101

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient's name and date of birth Patient's name and date of birth

_____ _____
Patient's name and date of birth Patient's name and date of birth

I, the undersigned, hereby authorize the following individual or organization (please include name, address, phone number, and fax number if possible):

_____

_____

_____

_____

to release copies of medical records of my child(ren) named above to **Benjamin N. Wan, MD, INC**.

Information to be released:

_____ All medical records
_____ Copy of immunization records only
_____ X-ray/Lab results only (dates: From _____ to _____)
_____ Other (Please specify: _____)

I understand that I am not required to sign this authorization and may in fact refuse to sign it. I may inspect or copy the protected health information in question, as permitted by federal privacy regulations. This authorization and consent will expire ninety (90) days following the date signed unless I choose to revoke in writing prior to the expiration date.

_____ _____
Parent/Guardian Signature Date

_____
Print name and relationship