Benjamin N. Wan, MD, INC
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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 **Benjamin N. Wan, MD, INC** to release copies of medical records of me or my child(ren) named above to the following individual or organization (please include name, address, phone number, and fax number if possible):

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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.

______________________________	______________________
Signature (Parent/Guardian if patient is a minor)	Date

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Print name and relationship

***A $0.25 per page charge will apply if records are not released directly to another physician or medical facility. **Please note that because of the HIPAA guidelines, we are not allowed to release any Psychological testing records. You must request those from the specialist that provided that service.**