ONG INSTITUTE for Plastic Surgery and Health
9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T: 480-771-7771 | E: concierge@onginstitute.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Social Security Number:_____

Other identifying information if applicable (other names): _____
Transmission by facsimile or electronic means authorized to expedite transfer of records.

I, _____ [your name] hereby authorize _____ [physician name] to release the records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to: Ong Institute for Plastic Surgery & Health , Cheri Ong M.D. 9377 E Bell Road, Suite 363 Scottsdale,, AZ 85260. For the following purpose(s). Medical Records and to continue health care.

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Ong Institute for Plastic Surgery & Health. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. **My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.**

_____ _____
Name Date

Name: DOB:

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EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from _____ to _____ [insert dates]:

- ☐ Complete medical record (all information)
- ☐ All hospital/institution records (includes nursing records/progress notes)
- ☐ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
- ☐ Laboratory reports
- ☐ Pathology reports
- ☐ Diagnostic imaging reports
- ☐ EKG/cardiac reports
- ☐ Physical/occupational therapy reports
- ☐ Billing statements
- ☐ Physician office/clinical records
- ☐ Implant information (including operative report)
- ☐ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

HIV/AIDS information

Mental health information

Genetic testing information

Drug/alcohol diagnosis, treatment, or referral information

Name: DOB: