THOMAS J. ASCIUTO, MD CORP

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

First Name: _____ Last Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Authorizations:

I hereby authorize:

Thomas J. Asciuto MD Corportation
18111 Brookhurst St. Suite 4600
Fountain Valley, CA 92708
Phone: (714) 861-4545 Fax: (714) 861-4549 Email: oclungdoctor@gmail.com

To release my health information to:

Recipient Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

Information Disclosure:

- ◯ All Records
- ◯ Progress Notes
- ◯ Radiology Report(s)
- ◯ Laboratory Result(s)
- ◯ EKG
- ◯ PFT
- ◯ Other (specify): _____

Expiration

This authorization shall become effective immediately and shall remain in effect for ninety (90) days from the date signed.

Restriction

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Signature (as required by law):

Signature: _____ _____

(Patient/Legal Guardian or Representative) Date

If signed by other than the patient, print name and relationship:

_____ _____

Name Relationship