Mike S. Shin, M.D.
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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:____

Date of Birth:___________________________________SS#:____________________________________

Previous Name:____

I request and authorize: Name:____

Address:____

City, State, Zip:____

Phone#______________________________Fax#___________________________

To release health care information of the above named patient to:

Name:____

Address:____

City, State, Zip:____

Phone#______________________________Fax#___________________________

This request and authorization applies to:

____Health care information relating to the following treatment, condition, or date of treatment:

____

____All health care information ____Other:__________________________________

I understand that my express consent is required to release health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS Virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature:____Date:_______________________________

Witness:____Date:_______________________________

This release of information will expire one (1) year from the above date patient or responsible party signature was obtained. This release of information may expire sooner, if date is specified here:____