



AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please REQUEST medical information from:

Name of Health Care Provider / Medical Office / Hospital:

Street Address City State Zip Code

Please SEND Medical Information to:

LK HEALTH
901 W. Whittier Boulevard
Montebello, CA 90640
(323) 728-8588 Fax (323) 728-4444

I hereby authorize Name of Health Care Provider / Medical Office / Hospital noted above to release and/or disclose the medical information as indicated below to the Clinic I have indicated above.

Release and/or disclose records and information regarding:

Name of Patient (List All Names Used) Medical Record Number Date of Birth

Street Address City State Zip Code Telephone

Table with 2 columns: Label (DURATION, REVOCATION, REDISCLOSURE, SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED) and Description/Options.

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only:

Continuity of Care Other

A copy of this authorization is valid as an original.

I have the right to receive a copy of this authorization. The copy is for me to keep.

Signature of Patient or Patient's Representative

Indicate Relationship (if signed by other than patient)

Date