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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize **Dennis H. Kim, M.D., LLC** to release my medical records or copies of such records and request that they be sent to the facility listed below. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected. I consent to the release of protected health information, which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

Date: _____
Patient Name: _____
Date of Birth: _____

To: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Please indicate the reason for this request:

_____ Copy for my personal record
_____ Consulting a new physician
_____ Transferring medical care to another allergist
_____ Moving out of the area
_____ Other _____

Signature: _____ _____
(Signature of Patient or Legal Guardian) *(Relationship to Patient)*

_____ _____
(Print Name of Patient or Legal Guardian) *(Today's Date)*

This authorization will expire one year from date above.
For Office Use Only: Date of Disclosure: _____
By: _____