HIPAA Compliant Authorization
To Release Medical Records Pursuant to 45 CFR 164.508

I, _____ authorize any physician, nurse, or other health care professional who has attended me or any hospital at which I have been confined to furnish to Jennifer Chu, M.D., LLC., or any authorized representative thereof, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefore and if necessary to allow them or any physician appointed by them to examine any x-ray/CT/MRI pictures taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records under the same terms and conditions.

A photocopy of this document may be used instead of the original.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedure Act, 1976, and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time, by written, dated communication to Jennifer Chu, M.D., LLC. and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, Jennifer Chu, M.D.,LLC. cannot prevent re-disclosure by the recipient

Expiration Date:

_____ 1 year from date of authorization

_____ Other (please specify)_____

_____ _____

Witness Patient Signature

Date _____

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