Petson Chan Acupuncture

Authorization For Medical Records Release

Please release the medical records of:

Patient Name:	
Date of Birth:	
Address:	
Phone:	

From:

Petson Chan Acupuncture
19 West 21st St, Suite 904
NY, NY 10010
347-903-7059

To The Below Authorized Individuals/Offices:

1	Name:	
	Address:	
	Phone:	Fax:
2	Name:	
	Address:	
	Phone:	Fax:
3	Name:	
	Address:	
	Phone:	Fax:

Medical records requested will require a prepayment fee for copies at $0.50 per page. This authorization also permits the discussion of patient medical information to the above authorized individuals/offices. This authorization is in effect until revoked by patient via written notice starting from the date of signature. Photocopies and faxed copies of this form are valid.

Patient Signature: _____ Date: _____

Dr. Petson D. Chan-Vanklein DACM, LAc, DiplOM
Petson Chan Acupuncture – 19 West 21st Street, Suite 904 – NY, NY 10010
1-347-903-7059 – petsonlacap@gmail.com
www.petsonacupuncture.com