AUTHORIZATION AND REQUEST FOR MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider as indicated.

FROM:	Dr. Albert Kim MD	TO:	Las Palmas Medical Group Corp.
ADDRESS:	1435 S. Grove Ave Suite 8	ADDRESS:	602 N. Euclid Avenue
	Ontario Ca. 91761		Ontario, CA 91762
	CITY, STATE & ZIP CODE		
PH:	909 983-0027	PH:	(909) 391 - 3423
FAX:	909. 984-1220	FAX:	(909) 391 - 3424

RELEASE RECORDS AND INFORMATION REGARDING:

PATIENT: Lethicia J. Serrato DOB: 4-28-57 PH: 909-678-8199
ADDRESS: 220 Nth Monterey Ave. Apt A
Ontario Ca. 91764
CITY, STATE & ZIP CODE

DURATION:	This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature in no date entered.
REVOCATION:	This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extend that the requester or others have acted in reliance upon this authorization.
REDISCLOSURE:	I understand that the request may no lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.
SPECIFY RECORDS:	Medical Information: _____ From: _____ To: _____ HIV Results: _____ Complete Medical Record: _____ Other: _____ (Specify) _____

Patient Signature: X Lethicia J. Serrato Date: Sept. 28, 2020

I request that the health information released pursuant to this authorization be used fro the following purposes only:
A copy of this authorization is valid as an original

I have the right to receive a copy of this authorization and the copy is form me to keep

Signature of patient or patient's representative: _____ Date: _____

Indicate relationship (if signed by other than the patient): _____