# Danny Fong, M D, P. C.

**Plastic and Reconstructive Surgery**
**Hand Surgery**
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## AUTHORIZATION FOR RELEASE OF MY MEDICAL RECORDS

TO:_____ Date:_____

Patient Name _____

Date Of Birth _____

This authorization to release my medical information is being requested in compliance with the general terms of the confidentiality of medical information.

By my signature below, I authorize Dr. Danny Fong and his practice to discuss or release all information, including medical records, x-rays, history, and findings and prognosis pertaining to my medical condition, services rendered me, or treatment given me to the following provider/entity:

_____

Limitations on discussion and release, if any:

This authorization (circle one) DOES / DOES NOT apply to testing regarding HIV status.

This authorization shall remain in effect for one year or until canceled in writing.

_____
Signature of patient/parent/conservator/guardian/ or patient's representative

_____
Date