Jackie T. Chan, M.D., Inc.
809 Sylvan Ave., Suite 400
Modesto, CA 95350
(209) 529-4422 Phone
(209) 529-1711 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
_____
_____

I hereby authorize for you to release a copy of my medical records to:

Jackie T. Chan, M.D., Inc.
809 Sylvan Ave., Suite 400
Modesto, CA 95350

For the following purpose:

_____ Continuing Healthcare

_____ Other_____

The following dates of treatment: _____

Information Should Include:

_____ Office Visit Notes _____ X-Ray's, MRI's, CT Scan's, Myelograms, Bone Scans

_____ Surgery Reports _____ Lab Reports _____ Others: _____

THIS AUTHORIZATION IS VALID FOR SIX MONTHS FROM THE DATE OF CONSENT. I UNDERSTAND I AM ENTITLED TO A COPY OF THIS AUTHORIZATION UPON REQUEST. THIS AUTHORIZATION MAY BE REVOKED, BY ME, AT ANYTIME, IN WRITING.

PATIENT NAME: _____ **DOB:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____