Edward Diao, M.D.
Orthopaedic Surgery
Hand, Upper Extremity and Microvascular Surgery
Professor Emeritus, University of California, San Francisco

AUTHORIZATION TO RELEASE INFORMATION

I, _____, DOB: _____, authorize Dr. Edward Diao's office to release clinical, medical, psychiatric, drug and/or alcohol information to:

Name:
Address:
City, State, Zip
Phone:
Fax:

Date(s) of information to be disclosed from _____ (month, year) to _____ (month, year)

If this disclosure shall be limited to the following specific types of information, please check:

_____ All medical records related to (specify condition, treatment, etc.): _____
_____ All billing records related to (specify condition, treatment, etc.): _____
_____ Radiology films/images (specify test): _____
_____ Operative Reports
_____ Information for legal purposes
_____ Specific record/information as follows: _____

I understand that I may revoke this consent to release information at any time except to the extent that action has already been taken for the purpose specified above. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon and, if not earlier revoked, it shall terminate at the time that the expressed purpose of this consent has been fulfilled.

All disclosures made as granted by this consent shall be governed by 42 C.F.R., Part 2 which states: "This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42 C.F.R., Part 2) prohibits you form making any further disclosure of it without the specified consent of the undersigned. A general authorization for the release of medical, psychiatric, drug or alcohol related material is NOT sufficient for this purpose."

Patient's Signature	Parent, Guardian, or authorized Patient Representative
Date	Witness: Name and Title

450 Sutter Street, Suite 910 * San Francisco, CA 94108
Tel: 415-362-8880 * Fax: 415-362-8045
hands@sf.sc.com