

TLC Allergy & Asthma Associates, Inc.

OTTO LIAO, MD

American Board of Internal Medicine
American Board of Pediatrics
American Board of Allergy and Immunology

Practice Limited to Allergy

1101 E. Bryan
Suite B
Tustin, CA 92780

Fax (714) 838-2640
Tel (949) 452-3730

24411 Health Center Dr.
Suite 560
Laguna Hills, CA 92653

Patient Full Name: _____ **DOB:** ___/___/___

Previous/Other Name: _____
(If different than patient listed above)

This will authorize:

To Release to:

TLC Allergy and Asthma Associates, Inc.

1101 E. Bryan, Suite B

Tustin, CA 92780

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- Complete Records
- Lab
- X-Ray Reports
- X-Ray Films
- Immunization
- Other
- I am moving (New Address)

Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I want/need a second opinion
- I am changing doctor (provider)
- Dissatisfaction with care
- My insurance changed

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW**

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse (alcohol/drug abuse) |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Health/Depression (includes psychological testing) |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV-Related Information (AIDS related testing) |

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or Responsible Party: _____ **Date** _____