

Michael K. Kwok, M.D.

KWOK INTERNAL MEDICINE, A Medical Corporation

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Information requested from:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Information to be sent to:

Michael K. Kwok, M.D.

Diplomate, American Board of Internal Medicine

895 Sir Francis Drake Boulevard

San Anselmo, CA 94960

T: 415-925-3617; F: 415-925-3597

Patient's Identifying Information:

Patient's Name: _____

Address: _____

City, State, Zip Code: _____

Patient's Home Phone: _____ Cell Phone: _____

Patient's Date of Birth: _____

Specific medical records or reports requested:

I hereby authorize the above physician, medical practitioner, hospital, clinic or medically-related facility to provide Michael K. Kwok, M.D. any records, reports or other information regarding my medical condition or history.

Patient's signature: _____

Date: _____