# 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

1300 South Eliseo Drive, Suite 203

Greenbrae, California 94904

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:** _____