# EVANGELINE ROXAS-BUTLIG, MD, INC.

PEDIATRIC & TEEN CLINIC

**Torrance Clinic:**
1727 Crenshaw Blvd.
Torrance, CA 90501
(310) 373-7855

**Carson Clinic:**
1000 E. Dominguez St, Suite 110
Carson, CA 90746
(310) 715-7755

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Section A: Must be completed for all authorizations**

I hereby authorize **Evangeline G. Roxas-Butlig, MD, Inc.** and/or his/her/its staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer by protected by federal or state law

**Patient's Name:** _____ **Date of Birth**:_____

**Persons/organizations receiving information:**

_____

_____

_____

**Specific description of information to be used or disclosed (including date(s)):**

_____

_____

_____

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**Section B: Must be completed only if a health plan or a health care provider has requested the authorization.**

1. **The health plan or health care provider must complete the following:**
   A. What is the purpose of the use or disclosure:

   _____

   _____

   (no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)

   B. Will the health plan or health care provider requesting the authorization receive financial or in- kind compensation in exchange for using or disclosing the health information described above?

   ☐ Yes ☐ No

2. **The patient of the patient's representative must read and initial the following statements:**

   A. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

   Initials: _____

   B. I understand that I may see and copy the information described on this form if I ask for it and that I will receive a copy of this form at I sign it.

   Initials: _____

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**Section C: Must be completed for all authorizations**

The patient or the patient's representative must read and initi al the following statements:
THE AUTHOR IZATION WI LL REMA IN IN EFFECT:

_____ From the date of this authorization until _____/_____/_____(DD/MM/YYYY)

_____ Until the following event occurs _____

I understand that I may revoke this authorization any time by notifying **Evangeline G. Roxas-Butlig, MD, Inc** in writing, but if I do it won't have any affect or any actions taken before receipt of revocation.)

**UNLESS OTHER WISE NOTED ABOVE, THIS AUTHORIZATION WILL REMAIN IN EFFECT 180 DAYS (one hundred eighty days) FROM THE DATE SIGNED BELOW.**

_____ _____

**Signature of patient or patient's representative** Date
*(Form MUST by completed before signing)*

Printed name of patient's representative (if applicable): _____

Relationship to patient (if applicable): _____