The Oncology Institute of Hope & Innovation

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, Noriko Simpson hereby authorize **THE ONCOLOGY INSTITUTE OF HOPE AND INNOVATION** to release my protected health information to the following:

Name: Dr. Ge at Clovis Community

Address: 6121 N Thesta #204 Fresno, CA 93710

Check off reason of request for records

- ____Social Security or Medi-cal Appeal
- ____Insurance/Medi-cal Application
- __X__Change of Providers
- ____For Own Personal Use
- ____Moved or Insurance change would like for new physician
- ____Other please indicate reason_____

The information that may be used or disclosed is as follows:

__X__ Complete History and Records

__X__ Laboratory Results

__X__ Most Recent Notes

__X__ Pathologic Reports

___ Other (Please Specify) _____

For the period of 01/01/2019 **through** 01/01/2024

DURATION: This authorization shall become effective and shall remain effective until _____ or for the period of one year from the date of signature if no date is entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned requestor.

PATIENT INFORMATION

A copy of this authorization is valid. I understand that I have the right to a copy of this authorization.

Print Name: Noriko Simpson Date of Birth: 11/02/1986

Phone #: 559-859-3362 Date: 01/29/2024

Signature: Noriko Simpson

Signature of Legal Representative (if applicable): _____

Print Name of Legal Representative: _____

Relationship of Authority to Act for Individual: _____