

Authorization For Release of Health Information

Authorized recipient	Name	Phone No.
	Date of Birth (Alien Registration No.)	Relationship with power of attorney grantor
	A d d r e s s	

Surrogate	Name	Phone No.
	Date of Birth (Alien Registration No.)	
	A d d r e s s	

I (surrogate) hereby grant any and all powers of attorney to the authorized recipient above to do in respect of release of my health information including copies of medical records on my behalf, according to the third clause of Article 21 of Korean Medical Law, and the third clause of Article 13 of Regulation of the same law.

_____ / _____ / _____ (Day/Month/Year)

_____ (signature)