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			
Power of attorney grantor	Name		Phone No.	
	Date of Birth			
	A d d r e s s			

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

_____/_____/_____ (date/month/year)

_____ (signature)

ASAN Medical Center