

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ SSN#: _____

Phone#: _____

Information is to be released by:

Name of Physician

Street Address

City, State, and Zip Code

Phone

Information is to be sent to:

Individual/Agency/Facility

Street Address

City, State, and Zip Code

Phone

All and complete Medical Records
or

These Specific Dates: _____ to _____

Information to be released:

Complete health record _____ Pathology Reports _____ Radiology report

Laboratory test results _____ Complete billing records _____ EKG reports

Other (specify) _____

Purpose of request:

Treatment or consultation _____ At the request of the patient

Billing or claims payment _____ Other
(specify) _____

Drug and/or alcohol abuse, and/or Psychiatric, and /or HIV/AIDS Records release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexual transmitted disease, Hepatitis B or C testing, and or other sensitive information, I agree to its release. yes no

Time Limit & Right to revoke authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this authorization by submitting a notice in writing to Christopher Kling, M.D., Inc to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____ or 90 days from date of signature, unless otherwise specified.

Re-release

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and no longer protected by The Health Insurance Portability Act of 1996. The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative who may request disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information specified above.

Signature: _____ **Date:** _____

Other Authorized Signature
(parent/guardian) _____ **Date:** _____

Witness: _____ **Date:** _____