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Authorization for Release of Medical Records

Patient Name:_____

Patient Address:_____

Patient DOB:_____

Telephone Number:_____Social Security Number:_____

I authorize the records to disclose/release the following information**(Check all applicable)

_____ All Records

_____ Laboratory/Pathology Results

_____ X-ray/Radiology Records

_____ Office Notes

_____ Other:_____

***Note: If these records contain any information about drug/alcohol abuse, sexually transmitted disease, or psychiatric issues, you are hereby authorizing disclosure of this information.*

Please release the records FROM:

_____
(Complete name of person/organization)

_____
Address

_____
City, State, Zip Code

_____
Phone Number/Fax Number

And send records TO:

Kim P. Kuhar, D.O. Internal Medicine, PC
165 W. Main Street, PO Box 420
Silverdale, PA 18962
P: 215.258.3810 | F: 215.258.3815

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

_____ _____

Signature of patient or patient's representative | Date