Kim Kuhar, D.O.
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KUHAR MEDICAL
Internal Medicine, PC • Cosmetic Services

164 West Main Street • Silverdale, Pa 18962
Phone: 215.258.3810 • Fax: 215.258.3815

Polly James, CRNP
Melissa Wagner, CRNP

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