Michiana Wellness

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

I hereby authorize Jennifer Knapp, D.O. to release or obtain medical records held in my name to/ from the person or agency designated below. The records to be released or obtained may contain but are not limited to information related to mental or emotional symptoms, HIV, alcohol or substance abuse, and/ or diagnoses and treatment for these conditions, including psychiatric hospitalizations and the use of psychiatric medications. I further authorize the release of information related to my medical and physical conditions, diagnoses, and treatments.

MEDICAL/ PSYCHIATRIC RECORDS MAY BE RELEASED TO OR OBTAINED FROM: (include name, address, and phone number, OR attach business card)

This Authorization is to remain in effect until retracted by the patient from the date indicated below and allows for exchange of medical information by telephone or other direct verbal communication in lieu of written communication.

_____

Patient Signature & Date