AUTHORIZATION TO RELEASE INFORMATION

Patient Name:

Patient Address:

Medical Record #: xxxxxxx

Date Of Birth: MM / DD / YY

Other Identifier (Social Security Number):

"I hereby authorize this practice to make uses and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

If > 30 pp, please send digitally, via disc or to secure email below*

If , 30 pp, please fax to: 860-435-3561

Name of Entity: Michael J. Kelly, MD

Attention of: Anne

Street Address of Entity: 16 Conklin St, Box 585

City: Salisbury State: CT Zip: 06068

*mkelly@1532.securemail.prognocis.com

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

REASON FOR REQUESTED USE OR DISCLOSURE:

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
c. The practice will not condition treatment or payment based on my signing this authorization
d. I am signing this authorization freely
e. No one has pressured me to sign this authorization
f. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law
g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
h. I have received a copy of this authorization.

Patient Signature:		Date:
Signature Of Patient's Representative:	Relationship:	Date:

FOR OFFICE USE ONLY

Event or Date Upon Which Authorization Will Expire: