

AUTHORIZATION TO OBTAIN / RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____ Phone #:(____) _____

Complete all bolded sectionsSelect ONE of the following: ☐ Kriska Health to provide medical information☐ Kriska Health to obtain medical information from _____A. Reason for request (select One of the following): ☐ Continued care ☐ Insurance ☐ Attorney☐ Personal Use ☐ Other _____

B. Information needed (select from below – a fee may be charged for copies of an entire encounter or all records.)

☐ Complete patient chart ☐ Office Notes ☐ Consultation notes and reports☐ Diagnostic study reports ☐ Lab Reports☐ Medication prescription logs, staff contact, other records that may not be part of my individual medical record, but which contain information related to me.☐ Other (specify): _____C. How to share information: ☐ Pick up ☐ Mail ☐ *Fax

Name of person to pick up or receive information: _____

Address: _____

*Fax Number including area code (patient care only): _____

I understand the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I must do so in writing to the Medical Records Services Department. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____

Date: _____

When someone other than patient signs, the following must be completed

I, _____ (print name) hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have lawful authority to enter this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization and agree that Kriska Health, PLLC may disclose the medical information of such individual for the purposes set forth herein.

Signature of Representative: _____ Date: _____

Relationship to Patient: _____

Reason patient unable to sign: _____

Remaining Section to be completed by Kriska Health Staff

Date Information Released: _____ Initials of who completed release: _____

Medical Record Number: _____ Date of completion: _____