KKAUR MD

Authorization to Release Medical Records

KKaur MD
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Patient Name: _____ DOB: _____

Authorization for Use/Disclosure of Information: I, the above-named patient (or the Parent or Legal Guardian), request and authorize **KKaur MD PLLC** (Provider) **D.B.A. KKaur MD** to provide my medical records containing the health information described within to the recipient that I have identified below:

Recipient:

I authorize and request that my health care information be released to the following:

Physician / Facility Name:
_____

Address:
_____
_____

Telephone: _____ Fax: _____

Information to be disclosed:

I authorize the release of the health information by checking the applicable box(es) below:

- ❑ All of my health information that the Provider has in its possession, including information relating to any medical history, including any mental or physical condition, and any medical treatment that I have received.
- ❑ Only the following records or types of health information:
  _____
  _____
  _____
  _____
  _____

Term: This Authorization will remain in effect until the Provider fulfills this request or the Patient revokes this Authorization.

Redisclosure: I understand that the Provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and if I change my mind, I do understand that I can revoke this Authorization by providing a written notice of revocation to the Provider at the address provided to me.

_____ _____

Signature of Patient / Legal Guardian Date Signed

If the Patient is unable to sign this Authorization, please complete the information below:

_____

Name of Legal Guardian

Relationship to Patient: _____