

## Authorization for Release of Health Information

Name \_\_\_\_\_ Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

I request and authorize Katz and Kade, Inc. to release my health information which may include medical records and claims and billing information, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, and demographic information. I understand that Katz and Kade, Inc. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Information to be disclosed (choose one):

All of my health information

My health information relating to the following treatment or condition(s):

\_\_\_\_\_

My health information for the following dates: \_\_\_\_\_

All claims and billing information only

Other: \_\_\_\_\_

Disclosure/release is to be made to (name, address, zip code and phone): \_\_\_\_\_  
\_\_\_\_\_

Purpose of the disclosure/release:

At my request

Other (specify): \_\_\_\_\_

This authorization expires (choose one):

One year from the date it is signed

On the following date: \_\_\_\_\_

I understand that I may refuse to sign this Authorization and that I may revoke it at any time but I must do so in writing to \_\_\_\_\_ at the following address: \_\_\_\_\_.

The revocation will not be effective to the extent that \_\_\_\_\_ has already disclosed the information. I understand that I have the right to request a copy of this Authorization after it is signed. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

If signed by a person other than the patient, please indicate relationship and authority to do so:

Legal Guardian

Power of Attorney

Parent of minor child

Personal Representative of deceased

Reason (if leaving our practice) \_\_\_\_\_.