KENNEDY HEALTH ALLIANCE™

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I authorize the use or disclosure of the above named individual's health information as described below.

Treatment Dates: _____ to _____

The type information to be used or disclosed is as follows:

_____ Treatment/visit notes _____ EKG _____ Reports _____ Medication Lists

_____ Lab results _____ Radiology Reports _____ Consult reports

Other: _____

This information may be disclosed to and used by the following individual or organization:

Name/Organization: _____

Address: _____

Reason/Purpose for the request: _____

☐ If this box is checked, the disclosure of information is for marketing purposes that involve direct or indirect remuneration to the Kennedy Health Alliance.

I understand that information in my health record may include information relating to HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), psychological or psychiatric conditions or treatment, sexually transmitted diseases or drug/alcohol abuse/dependence status, detoxification or rehabilitation services.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my revocation to the Kennedy Health Alliance. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____ . If I fail to specify an expiration date, this authorization will expire in six months.

I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign the form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient