Steven C. Kronlage, MD, PA

Authorization for Disclosure of Health Information

Section A (Required) Full Patient Name_____ Date of Birth _____

Select One: (Choice 1) I authorize Steven C. Kronlage, MD, PA to disclose my health information as described below.
(Choice 2) I am the patient (or patient's legal guardian, attorney-in-fact, etc.) and seek access to my own records.
(Choice 3) I authorize Steven C. Kronlage, MD, PA to receive the information described below from :

Name of Entity/Person Authorized to disclose information_____

Section B (Required only if Choice 2 selected in Section A)

____ I would like you to send a copy of these records to me at my address listed below. (Advance payment will be required*)
____ The following person will pick up a copy of these records at your office. (Payment required at pick-up*)

_____

____ I would like to make an appointment to look at these records at your office.

(* The payment requirement may be waived when a patient is picking up and hand delivering records to another healthcare provider for further treatment. If this is your intention, please provide the name, address and telephone number of the healthcare provider who will ultimately be receiving the records, in the section below.)

Section C (Required) Name of person/entity who will receive information_____
Address_____ Telephone_____
Purpose of Disclosure of Information_____
Description of Specific Information permitted to be disclosed (include dates where possible):_____

_____

I specifically authorize the disclosure of the following type(s) of information, if included in information requested above:
Mental Health (initials)_____ Drug and/or Alcohol Abuse/Treatment(initials)_____ HIV Status (initials)_____

This Authorization will expire within 90 days unless otherwise stated here: _____
I understand I have the right to revoke this Authorization at any time. I may not revoke it to the extent that the entity disclosing the information has already relied upon it. In order to revoke this Authorization, I understand that I must revoke it in writing to the Administrator at Steven C. Kronlage, MD, PA. Where it involves another entity's record, I must revoke it in writing to the entity disclosing the records. I understand that the information disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the Privacy Protections provided to me under the Privacy Laws that protect health information. I understand that Steven C. Kronlage, MD, PA may not require that I sign this Authorization in order to obtain treatment. I understand that I have a right to request to inspect the information disclosed, or to get a copy at my expense, from the entity that I authorized to disclose the information. **I have read this Authorization, or had it explained to me, and I understand its contents.**

Signature_____ Date_____
Daytime Telephone:_____

If this Authorization is signed by the patient's legal representative, the following is the legal basis for his/her authority:
___Power of Atty ____ Guardianship Order ___ Parent of Minor ____Executor ___ Other
(Proof Attached)