**AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM NKH**

Patient Name_____ Date of Birth_____

Address_____ Telephone_____

***I hereby authorize New Kingdom Healthcare to release the following medical information on the above listed patient to:***

_____

Name/Organization Telephone Fax#

_____

Address

[ ] Complete Health Record [ ] Wellness Visits [ ] Laboratory Reports
[ ] Behavioral Visits [ ] Sleep Visits [ ] Illness Visits
[ ] Other (Specify condition/diagnosis)_____

For the following time period (specify dates): From_____ to_____

I am requesting this information for use by:

[ ] Medical Personnel/Health Care Facility [ ] Attorney [ ] Insurance Company
[ ] Personal/Self [ ] Law Enforcement
[ ] Other (Specify)_____

***I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect or copy the information to be used or disclosed. I understand that written notification is necessary to cancel this authorization. I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. This authorization is effective for one year from the date signed unless otherwise indicated.***

_____

**Signature of Patient/Parent/Guardian/Legal Representative** **Relationship to Patient** **Today's Date**

Method of Delivery: [ ] Will pick up [ ] Mail Info [ ] Electronic [ ] Fax

**OPTIONAL:** Per federal law the following information **will not be released unless signed below**. I specifically authorize the release of information relating to:

[ ] Substance Abuse (alcohol/drug abuse) [ ] Mental Health (includes psychological testing)
[ ] HIV-Related Information (AIDS related testing) [ ] Developmental Disabilities

_____

**Signature of Patient/Parent/Guardian/Legal Representative** **Relationship to Patient** **Today's Date**

OFFICE USE ONLY: Request Completed by _____ Date_____