KDS Aesthetics
Karen D. Szymanski, DO, FACOS

Authorization for release of personal health information

First Middle Last Date of Birth Last 4 SSN

I hereby authorize:
Doctor/Facility: _____
Address: _____
_____
Phone#: _____
Fax#: _____

Disclose information to:
Doctor/Facility: _____
Address: _____
_____
Phone#: _____
Fax#: _____

Please release the following medical information on the above referenced patient:
( ) Clinical notes, photos, lab, x-ray reports, immunizations related to the following service date or condition:
_____
( ) Entire medical record including any immunization records
( ) Any restrictions: (Please list)
_____

This disclosure is being made for the following reason(s):
_____ Transfer of Care _____ Attorney _____Referral _____ Moved out of area
_____ Insurance _____ Workmen's Compensation _____ Personal Use
_____ Other: Please describe: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization.
I understand this authorization is subject to revocation at any time by written notification by me except to the extent that the facility which is to make the disclosure has already acted in reliance on it.
I understand my signature on this form authorizes the release of my personal Health Information to the entity listed until revoked by me in writing or in 1 (one) year.

_____
(DATE) **(Signature of patient / Legal Representative)**

_____
(Witness) **(Relationship of Legal Representative to Patient)**

_____

(INTEROFFICE USE ONLY)
ACCOUNTING OF DISCLOSURE

RECORDS RELEASED:
( ) FAX ( ) MAILED ( ) OTHER
DATE: _____ INITIALS_____

RECORDS RECEIVED:
DATE: _____ INITIALS_____

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