Authorization for Release of Health Information

1. I, _____, SS# _____, DOB _____, authorize _____ to release or disclose health information as described below to:

   NAME: _____ (the "Receiving Party")
   ADDRESS: _____
   _____

   (Please check each part of your record to be included)

   _____ Complete Copy of Medical Record
   _____ Psychologist notes (in addition to to medical records requested)
   _____ Occupational Therapy Notes
   _____ Other (please describe):
   _____
   _____

2. The authorization for release of my health information is provided for the purpose of (i.e., individual's request, insurance, continuing care) _____
   _____

3. This authorization is made in accordance with the federal and state law and is valid for a period of six (6) months after being signed. Alternatively, this authorization shall expire if and when _____
   _____

4. I understand that I may revoke this authorization at any time by sending a written revocation to Kalamazoo Anesthesiology, P.C., except to the extent that it has taken action in reliance on the authorization.

5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.

6. I understand that my continued or future treatment by, or payment to, Kalamazoo Anesthesiology, P.C. is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.

7. I understand that if _____ is the Receiving Party, I have the right to inspect or copy the health information they (Receiving Party) intend to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

8. I have been provided with a copy of this authorization for my records. _____ (initials)

_____ / _____ WITNESS: _____
Patient's Signature Date

_____
Relationship to Patient if signed by individual other than Patient and basis for authority to act on behalf of the patient

_____ _____
Street Address City, State, Zip Code