Authorization to Use or Disclose Protected Health Information

Patient
Name:_____Address:_____

Phone:_____ Date of Birth: ____/____/_____

I hereby authorize Dr. Robyn Kutka of Robyn Kutka ND, LLC to disclose my Patient Health Information to: *(please fill in receiving practitioner's name and office address below)*

*By **initialing** the spaces below, I authorize the release of the following records, if such records exist:*

____ Entire medical record ___ Progress notes ___Laboratory report

____ Pathology reports ___ EKG ___X-ray

____ Operative report ___ Other, Please be specific:_____

The following items must be initialed to be included in other documents:
___ HIV/AIDS related record ___Mental Health records
___ Drug/Alcohol diagnosis, treatment or referral information ___Genetic testing information

Federal regulations require a description of how much information and what kind of information is to be disclosed: _____

For the specific purpose of (describe in detail):

_____

This authorization will expire 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:
Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.

1. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.
6. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ ____/_____/_____
Signature of Patient or Patient's Authorized Representative (relationship) *Date*