

MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete the following information:

Patient name: _____

Address: _____

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

I, _____ hereby authorize
the following physician/ medical facility:

Name of Person or Entity (Please print) Phone

Address (City, State, and Zip) Fax

to release medical records and information to **Memor Health (Yvette Kaunismaki M.D., P.C. dba)**

**** (check all that apply)*

____ All Records ____ Abstract/Summary ____ Lab/Pathology Records

____ Pharmacy/Prescription Records ____ Mental Health Records ____ History/ Physical Exam

____ Chemical Dependency/ Substance Abuse Records ____ Consultations

____ Other (describe specifically) _____

****Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Purpose of Release:

_____ Continuing Care _____ Transfer of Care _____ Insurance Payment/ Claim

Other: _____

