RELEASE OF INFORMATION AUTHORIZATION

Patient Name:____ DOB:______________________________

I request and authorize Clara Kim, MD to release and receive health information from:

Name:____ Phone #:______________________________

Address:____ Fax #:________________________________

City, State, Zip:____

Clara Kim, MD

300 W Main St, Bldg B

Northborough MA 01532

Phone: (508) 723-6141

Fax: (508) 393-7093

This request and authorization applies to only the following protected health information:

(Please initial to specifically authorize the use and/or disclosure of:)

____ Initial Psychiatric Evaluation

____ Outpatient Progress Notes

____ Medication History

____ Psychological Test Report

____ X-Ray Reports (_________)

____ Other (___________________________)

____ **Initial Here for All of the Above**

____ Clinical Summary

____ Discharge Summary

____ Verbal Communication

____ Consultation Report (_________)

____ Laboratory Reports (_________)

Purpose(s) of this use/disclosure: ____ To coordinate care

During the following approximate time period or dates:____

Authorization expires:________________ If no date specified, the Authorization will expire 1 year after signed.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Clara Kim, MD. I understand that Dr. Clara Kim may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

I understand I may ask for electronic copies of my medical records to be sent to me or a designated third party. I understand and accept that any electronic medical records requested will be sent unencrypted and could be viewed by third parties.

Responsible party's name:____ Relationship:______________

Responsible party's signature:____ Date:____________________

Witness Signature:____ Date:____________________

I request a copy of this signed authorization: ____