Authorization to Release Medical Records

Complete the form below and submit to your healthcare provider.
This form should be downloaded and printed.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth (mm/dd/yyyy): _____ Phone: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

HEALTHCARE PROVIDER INFORMATION

The above patient is (or has been a patient of the following healthcare facility or provider:

Provider / Facility Name: _____

Provider / Facility Phone Number: _____

Provider / Facility Address (Street, City, ST, Zip): _____

The above patient authorizes the above healthcare facility/provider to release all medical records and to discuss health information with the following healthcare facility/provider:

KLARITY CLINIC OF CINCINNATI
Dr. Nirvana Kundu
7691 Five Mile Rd., Ste. 10
844.552.7489 / FAX 888.945.4264

I understand that release of medical records may include patient histories, office notes, and working diagnoses. It may include drug, alcohol or substance abuse records, mental health records, procedural and surgical records, test results, current and past medications and treatments. Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

Patient Signature: _____

Patient Name (printed): _____

Date Signed: _____