Karen F. Kuhns, M.D. **Internal Medicine**
285 SE 5th Avenue **Phone: 561-272-8991**
Delray Beach, FL 33483 **Fax:561-272-8985**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Names:_____ Social Security#:_____

I hereby consent to the disclosure and release of medical records pertaining to (please circle):

All records Lab results Imaging results Other (please specify):_____

FROM: Karen F. Kuhns, M.D.
285 SE 5th Avenue
Delray Beach, FL 33483
Ph: 561.272.8991
Fax: 561.272.8985

TO: _____

Phone:_____

Fax:_____

The question of privacy between the physicians at the sending facility and myself are waived. I fully understand that my medical record or information maintained in connection with the date(s) of service may contain mental health, alcohol, and drug abuse, Human Immunodeficiency Virus (HIV) test results or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed by this release are privileged and confidential and may be disclosed only on my authorization, except as required by law. Only such information believed to be necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the records that are disclosed. If I refuse to sign this authorization, my records will not be released.

This authorization is valid for one year from the signed date. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the releasing agency.

By my signature below, I state that I understand I will be responsible for any copying or production charges associated with these records. These charges include a charge of $1 per page up to 25 pages, and 25 cents for any page over 25 pages. If the chart I am requesting records from is in a storage location, I will be charged a $25 retrieval fee to get the chart from storage.

Patient Signature:_____ **Date:**_____

FOR OFFICE USE ONLY

MAILED/FAXED ALL REQUESTED INFORMATION BY _____ ON _____

RECORDS PICKED UP IN PERSON BY: _____ ON _____. ID SHOWN:_____