Susan Balk Kradel MD and Associates PA
1000 West 11th Street
Panama City Fl 32401
(850) 913-8313 Fax (850) 913-8314

Authorization to Release Medical Information

Patient:

Name _____ DOB _____

Address _____

City, State, Zip _____

Authorizes: _____ **To Protected Health Information To:**

Health Care Provider/Plan/Other _____ Health Care Provider/Plan/Other _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Information To Be Released:

Medical History/Exam/ Reports
Psychological Testing
Hospital Inpatient Records
Alcohol/Drug Abuse/Treatment
Mental Health Counseling
Medication / Prescriptions
Laboratory Studies
Sexually Transmitted Disease
HIV/AIDS
Psychiatric Care:
Inpatient Outpatient
Entire Record

For the following dates: _____

Purpose of the Disclosure:

Further Medical Care
Insurance
Legal
Personal
Other _____

Patient Rights Regarding This Disclosure:

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present to the office of Susan Balk Kradel, MD. I understand that revocation will not apply to information that has already been released. I understand that revocation will not apply to my insurance company when the law provides my insurer to a right to contest a claim under my policy. Unless otherwise revoked this authorization will expire six months from the date signed.

Signed: _____ **Date:** _____

Relationship to Patient: _____

Revised 4/14/03

Personal Health Information
Records Request / Amendment Request

I request:

____ *a copy or summary of the personal health information*

____ *an amendment to the personal health information in my record at the office of Susan Balk Kradel MD.*

I understand that I will be charged an administrative fee of $25.00 plus $1.00 per page for direct copies, or an administrative fee of $25.00 for a summary letter. I understand that I must pay this charge prior to receiving the requested information. I understand that I must allow up to 30 days for processing of this request.

I understand that with my authorization, this office will send a summary or exact copies of my record directly to the office of another health provider without charge.

I understand that information in a medical/psychiatric record is extremely private and personal, and that my review of this information may cause some difficulty in my ability to continue in treatment with Susan Balk Kradel MD. If I am a parent or guardian requesting this information about a child, I understand that my review of this information could cause difficulty in my child's ability to continue in treatment with Susan Balk Kradel MD.

I understand that if I request an amendment to the record, I must do so in writing. I understand that Susan Balk Kradel MD is not required to make the proposed amendment but will notify me in writing of the reasons for her decision. Please indicate specific request for amendment on reverse of this form.

_____ _____

Patient Name *DOB*

_____ _____

Parent/Guardian Name (If Applicable) *Relationship*

_____ _____

Signature *Date*

For Office Use Only

Date Received ***Date Provided***

Number Pages ***Charge***

Transmitted To: ***Means of Transmission***

Office Staff Signature _____