**Susan Kinkead-Acree, MD, PLLC**

**Psychiatry**



**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 First MI Last

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

**Tel**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTION REQUESTED (check one)**

I authorize Susan Kinkead-Acree, MD to take the following action:

* Provide a complete copy of my healthcare records to me.
* Provide a complete copy of my healthcare records to the person or entity below.
* Provide a copy of a portion of my healthcare records, limited to the following information, to the person or entity below:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Provide a treatment summary report to the person or entity below:

**Name of Person or Entity**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

**Tel**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **PURPOSE*** Medical Follow-Up
* Attorney
* Personal use
* Disability
* Insurance
* Other
 | **DISPOSITION*** Mail the records
* Email to the number above (encrypted)
* Fax to the number above
* I will pick up the records
 | **FEES**Pages 1-50: $0.50 per pagePages 51+: $0.25 per pagePostage: Added where requiredWritten treatment summary: Prorated at hourly rate of $250 |

I understand there will be a fee for a copy or written treatment summary of my healthcare information.

I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION, PAGE 2**

I understand that:

• This authorization is valid for one year from date signed, unless I revoke/withdraw this authorization or unless an earlier date is specified here: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. I may revoke/withdraw this authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing, faxing, or sending via encrypted email, my written request along with a copy of the original authorization to Susan Kinkead-Acree, MD.

• Once my healthcare information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

• The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

**Signature of Patient Only**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Required)

**If you are NOT the patient but are signing on behalf of the patient, please complete below:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the (check which applies)

First MI Last

* Court Appointed Guardian
* Medical Power of Attorney
* Power of Attorney with Right to See Medical Records
* Legally Appointed Healthcare Agent
* Court Appointed Personal Representative of Deceased
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You MUST attach proof of your authority to act on behalf of the patient as checked above.**

Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Required)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return signed form to Susan Kinkead-Acree, MD by fax, USPS, or via the LuxSci encrypted email service provided on the Forms and Handouts page on the website of Dr. Kinkead-Acree. A copy of the requested information will be sent immediately upon the receipt of payment in the form of cash or credit card; Visa, MasterCard, Discover, and American Express cards are accepted.**