THE KAPLAN CENTER
for Integrative Medicine
THE CHRONIC PAIN AND ILLNESS EXPERTS

Patient Authorization Form

I, _____, hereby authorize the disclosure of the following Protected Health Information (PHI):
(Patient's Name)

- ☐ Appointment and Account Information
- ☐ Medical Records
- ☐ Laboratory and Radiology Findings
- ☐ Attend appointments with no restrictions
- ☐ Insurance/Billing/Account Information
- ☐ Visit Notes
- ☐ Prescription Information
- ☐ Insurance/Billing/Account Information

I authorize the Kaplan Center to release this information to the following persons/offices/agencies:

Name: Address: Fax / Phone:

_____

_____

_____

_____

I am requesting this information be released for the following purposes(s):

Coordination of Care

Other: _____

This authorization shall remain in effect from the date signed below until: _____
(Date)

This date cannot exceed one year from the date signed and must be renewed annually. A photocopy of this authorization will be as valid as the original.

I understand that:

1. I may request a copy of the PHI that will be used or disclosed.
2. I may revoke this authorization in writing by contacting Kaplan Center.
3. Once the Kaplan Center completes my request to release my Personal Health Information (PHI), the Clinic is not responsible for any subsequent disclosure of my PHI.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Printed Patient Name) (Printed Name of Legal Guardian – if Applicable)