Kramer Davis Clinic – Nashville
3901 Central Pike, Suite 500
Hermitage, TN 37076
Phone: (615) 933-7300
Fax: (866) 611-2555 | kd.health

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION FROM OTHER ENTITIES

*Please include **one facility request** per page.*

TO: ______ **ATTN: Release of Information** ______

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RE: ______________________________

The following applies to the Health Insurance Portability and Accountability Act Privacy Regulations pursuant to 45 CFR §164.5

☐ The above named provider is hereby authorized to release to Kramer Davis Health all medical, mental health, and dental records including but not limited to: progress notes, intake forms, handwritten notes, emergency room records, operative records, in-patient records, out-patient records, discharge summaries, medical bills, and health insurance records, Medicaid or Medicare records, films of x-rays, MRIs or PET scans, mental health and HIV-related records, concerning any medical treatment that I have received from you or at your institution. A photostatic copy hereof shall be as valid as the original authorization.

The following applies to disclosure of alcohol or drug services whose confidentiality is protected by Federal Law 42 U.S.C. §§ 290dd-22.

☐ The above named provider is hereby authorized to release to Kramer Davis Health all medical, mental health, and dental records including but not limited to: progress notes, handwritten notes, emergency room records, emergency room records, operative records, in-patient records, out-patient records, discharge summaries, medical bills, and health insurance records, Medicaid or Medicare records, and films of x-rays, MRIs or PET scans, mental health and HIV-related records relating to any treatment or services I may have received from you or at your institution related to alcohol and/or drug/chemical dependency. A photostatic copy hereof shall be as valid as the original authorization.

The purpose of this Authorization and request is to obtain medical records pertaining to my physical and mental condition. I have the right to revoke this Authorization in writing by providing a signed, written notice of revocation to you.

You may not condition treatment or payment on whether I execute this Authorization. The information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. Any revocation of the Authorization is not effective with respect to actions a covered entity took in reliance on a valid Authorization and therefore, shall not apply to records produced by a covered entity prior to revocation. This Authorization is effective for two (2) years from the date of signing.

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Name of Patient

______________________________	______________________________
Name of Authorized Healthcare Decision Maker (Conservator)	**Relationship to Patient**
______________________________	______________________________
Patient Social Security #	**Date of Birth**
______________________________	______________________________
Signature of Patient/Guardian/Conservator	**Date**