Highlands Health For Life
Whitney Kennedy M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, being the patient (parent or legal guardian of the patient), do hereby request Highlands Health For Life to release medical records specified below to:

Clinic/Hospital/Physician/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ Summary of patient record including immunization records
_____ All records relating to _____ (please specify)
_____ Entire patient record

Specific restrictions, or items not to be released? _____

Reason for release of information:

_____ Consult/Second Opinion _____ Change of Insurance

_____ Out of town move _____ Change of physician

_____ Other (Please Describe) _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Authorization Expiration Date _____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. The provider cannot condition treatment, payment, and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature: _____ Date: _____

Witness: _____ Date: _____