Nat Kuhn MD
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# Authorization to Release Medical and Mental Health Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Your Name | First | MI | Last | | | | |
| Address | | | | Apt # | | Phone | ( ) - |
| City | | State | | Zip | | Birth Date | / / |

[Note: to decline any option, either un-check the box on the PDF, or use a pen to draw a single straight line through the box and the corresponding text.]

I authorize the following person or facility to ☑ release and/or ☑ exchange medical and/or mental health information to/with Dr. Nat (Nathaniel S.) Kuhn:

| | | | | | | |
|---|---|---|---|---|---|---|
| Name | Person or Facility | | | | | |
| Address | | | | | | |
| | | | | Phone | ( ) - | |
| City | | State | Zip | Fax | ( ) - | |

Information to be released:

| | | | |
|---|---|---|---|
| General Authorization | For medical, mental health, drug/alcohol, HIV/AIDS, genetic information **or** | | |
| Particular Information Only | Specify | | |
| Communication Method | ☑ Verbal Information and ☑ Copies of Records | | |
| Reason for Disclosure | ☑ Evaluation and/or Treatment ☐ At my request **or** | | |
| | Specify Other Reason | | |
| Term of Authorization | ☑ During my treatment with Dr. Kuhn **or** | Expiration Date | / / |

| | |
|---|---|
| **Conditions of Authorization** | I understand that:<br>• I do not need to sign this authorization, in which case no information will be disclosed.<br>• I will not be denied treatment if I choose not to sign this authorization.<br>• I am entitled to a signed copy of this authorization.<br>• I can revoke this authorization at any time, by written request to Dr. Kuhn.<br>• The revocation is effective immediately on Dr. Kuhn's receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request.<br>• Dr. Kuhn's privacy policy is available at his web site, at www.natkuhn.com/privacy |
| **Signature** | Signed: _____ Date: _____ |