AUTHORIZATION TO RELEASE INFORMATION

I, _____ give permission to MORGAN KALMAN CLINIC to disclose the following information from my health records. Any information listed below that I have crossed out may not be released. I give consent for the following information to be released:

1. Complete Health Record
2. History and Physical Examinations
3. Consultation Reports
4. X-Ray Reports
5. Discharge Summary
6. Progress Notes
7. Laboratory Results
8. Photos or other images

I understand this may include personal information relating to AIDS, HIV INFECTION, HEPATITIS INFECTION, or MRSA.

The above information may be disclosed to or received by:

ATTORNEY
HOSPITAL
INSURANCE COMPANY
MEDICARE (CLAIMS ISSUES)
OTHER CARE GIVERS (REFERRALS FOR ADDED CARE)

I also give consent for messages from Morgan Kalman Clinic to be released to:

❑ Left on home phone answering machine Phone #_____

❑ Left on cell phone voice mail Phone# _____

❑ Work voice mail Phone# _____

❑ Spouse Name_____

❑ Child Name_____

❑ Other Name_____

It is my preference to be contacted at: _____

I understand that this consent will remain a permanent part of my medical record and that does not expire. I also understand that I may, at any time, revoke this consent, or any part of it, in writing. I understand Morgan Kalman Clinic will do all in their power to see that any personal information is maintained in a professional manner and only released to those it deems appropriate to receive said information. I also understand that Morgan Kalman Clinic is required by Law to maintain the privacy of, and provide individuals with, this notice of their legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (302) 529-5500. My signature on this form acknowledges my completion of the above information and that I received a copy of Morgan Kalman Clinic's Notice of Privacy Practices.

Print Name:_____Signature:_____

Witness:_____Date of Signature and Witness:_____