MEDICAL RECORDS RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Phone: 386-951-6884 Fax: 386-960-8948

Date: _____ Account #: _____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by: _____

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to Dr. Jeffrey A. Kidd's Office

Name: _____ Social Security #: _____

Date of Birth:_____

I hereby request and authorize that the following medical documents/records to be released and that they be promptly transferred to Dr. Jeffrey A. Kidd's Office

_____ X-Ray / MRI / CT
_____ Complete Medical file
_____ Medical Reports
_____ Daily Notes
_____ Other _____

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Dr. Jeffrey A. Kidd's Office You should contact the Compliance Office to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____
Patient Signature Date

_____
Representative Signature / Please Print Name Date

Dr. Jeffrey A. Kidd
152 Treemont Drive
Orange City, FL 32763