

Dr. Kat, Naturopathic Physician - LLC
Dr. Kaitlyn N. Staal, ND, MSAc
125 Boston Post Rd. Suite #1, Waterford, CT 06385
P:(860) 271-7354 F:(203) 717-0214
Drkat.healing@gmail.com www.drkat.us

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEALTH INFORMATION

Patient Name _____ Social Security # _____
Date of Birth _____ Medical Record # _____

I hereby authorize Dr. Kat, Naturopathic Physician - LLC to use/disclose my individual health information as described below (which may include, but is not limited to information concerning treatment for drug/alcohol abuse, mental health; HIV status; communicable or venereal disease; genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I hereby authorize the use of disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

Name of Individual to Receive PHI	Name of Individual to Disclose PHI
Dr. Kaitlyn N. Staal, ND, MSAc Dr. Kat, Naturopathic Physician 125 Boston Post Rd. Suite #1 Waterford, CT 06385	_____ Address _____ _____

Information authorized for use of disclosure, or to be obtained:

- Medical Records Summary _____
- History / Physical / Consultation Reports _____
- Hospitalization Summaries _____
- Lab Reports / Ultrasound Films / Other Radiographic Summaries _____
- All of the above _____

Purpose of the use and/or disclosure:

Description of information to be disclosed:

- At the Request of the patient _____
- Insurance _____
- Continued Treatment _____
- Legal _____
- Other (specify) _____

I understand that I may revoke this authorization at any time in writing and the automatic expiration date is one year from the date of authorization. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider; the disclosed information may no longer be protected by federal and state privacy regulations.

Signature of Patient or Legal Representative

Date

(Description of Legal Representative Authority if not self: _____)