Authorization for Disclosure of Health Information

(1) I hereby authorize Kelly Karpa, PhD, RPh to disclose any health information she has obtained from me or my medical records. I understand that it is Dr. Karpa's intent to relay the information that we discuss to my health care provider(s).

Name:_____

Date of Birth:_____

Address:_____

_____

Telephone:_____

Covering the period(s) of service from _____ to _____

(2) This information may also be disclosed to _____ (spouse, children, etc.) , for the purpose of _____.

(3) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ (Specify date 60 days subsequent to the date of this release)

(4) I understand and acknowledge that because of my execution of this authorization all health information I have disclosed to Kelly Karpa may be disclosed to the person(s) I have identified in this form.

(5) Kelly Karpa, PhD, RPh is herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative Date

Signature of Witness Date