LUDA KAMENETSKY, M.D.

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____

LUDA KAMENETKY, M.D. is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: _____

_____

_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:
  _____
  _____

I release Luda Kamenetsky, MD, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Luda Kamenetky, MD, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

- ❑ Not satisfied with Provider (which provider? _____)
- ❑ Not satisfied with Staff (which staff member? _____)
- ❑ Moving out of the area?
- ❑ Other (Please describe :_____)

1315 ST JOSEPH PARKWAY #1101 HOUSTON, TX 77002
PHONE: 713-659-3781 • FAX: 713-659-6848
PLEASE MAIL ALL MEDICAL RECORDS