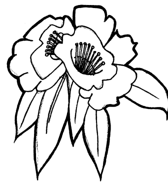
Pratistha Strong, D.O.
Kathmandu Clinic
111 Prospect Ave., Ste 202D
Kirkwood, MO 63122



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pratistha.strong@gmail.com
www.doctorpstrong.com

Medical Release of Information

Patient Name ______________________________ Date _____________

Date of Birth ______________________ Phone___________________________

I authorize: ____ to release my health information to Dr. Pratistha Strong, Kathmandu Clinic.

Phone: ___________________________ Fax: ___________________________

Purpose of disclosure:_____medical__________________

I specifically authorize the use or disclosure of the following health information:

___ ALL MEDICAL RECORDS

___ Radiology Reports _______________ from _______________

___ Chart Notes ALL or from _______________to _______________

___ Labs ALL or from _______________to _______________

___ Other (please list)_____________________________________

___ Verbal exchange of information between providers

I understand that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

____ Date _____________

(Signature of Patient or Patient's Legal Representative)

____

(Printed Name of Patient or Patient's Legal Representative)