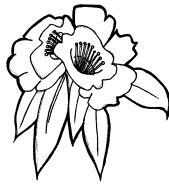


Pratistha Strong, D.O.  
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Kirkwood, MO 63122



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**Medical Release of Information**

MR#:

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

I authorize my health information to be released to Dr. Strong of Kathmandu Clinic from:  
(please list **doctor OR provider OR hospital**)

\_\_\_\_\_.

**Doctor's phone:** \_\_\_\_\_ **Doctor's 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)