Pratistha Strong, D.O.
Kathmandu Clinic
10807 Big Bend Blvd., Ste 1
Kirkwood, MO 63122

Cell: 918-814-3996
Fax: 432-614-2599
pratistha.strong@gmail.com
www.doctorpstrong.com

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)