KURT A. KUHLMAN, DO
JODI M. WILHELM, CNP
KATHY M. HARVEY, CNP
939 WEST MARKET STREET, SUITE 3
LIMA, OHIO 45805
419.516.0515
KURTKUHLMAN.COM

AUTHORIZATION TO RELEASE PERSONAL HEALTH CARE INFORMATION

While we have instituted the new formal policies required by HIPAA, we have always taken the protection of personal information very seriously. You may note some changes in the information that will be available as a result of the new requirements. For instance, we will no longer be able to provide information to a spouse or family member calling for information regarding your personal health care, including test results, without a written authorization from the patient. We regret the inconvenience of this new policy, but we are prohibited from releasing that information without an authorization from the patient.

List who you would like us to release your information to:

NAME	RELATIONSHIP	PHONE NUMBER

(circle one)

Starting date: _____ good until: 1 yr. 5 yrs. Life or other date: _____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient Signature: _____ Date: _____