Lea H. Kirkland, MD
Adult, Child & Adolescent Psychiatry

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT:_____

- The type of information to be used or disclosed is as follows:
  Complete medical file _____
  Office Notes ____
  Lab work _____
  Medication List _____
  Hospital Admit/Discharge _____
  Other _____

- The information described above may be used or disclosed to/from:

  _____
  Name of person or organization

  _____
  Address

  _____
  Telephone Number Fax Number

- This authorization will be in effect for one (1) year unless revoked or terminated by the patient or patient's representative.
- You may revoke or terminate this authorization by submitting a written revocation to Lea H. Kirkland, MD. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations. I understand and acknowledge that this *may* include information relating to alcohol/drug abuse, behavioral or mental health services, etc.

_____
Signature of Patient or Patient Representative Date

_____
Patient's Date of Birth Patient's Social Security Number