KOHLES FAMILY PRACTICE
BRIAN KOHLES, MD

Authorization to Transfer Medical Records

1. **Patient Information.**
   - **Name:** _____
   - **Address:** _____
     _____
     _____
   - **SSN:** ___ - __ - ____
   - **Date of Birth:** _____
   - **Records From:** _____

2. **Authorization For Release.** I, _____ , hereby authorize _____ to release, disclose, and deliver the medical information described below to:

   Authorized Recipient/s:
   Brian Kohles

3. **Specific Authorization,** I specifically authorize the release of ALL medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance Abuse (drug or alcohol) treatment; (2) Mental health treatment; and (3) HIV-AIDS- related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity.

I DO NOT give permission for any other use or redisclosure of this information

Patient: _____ Date: _____

4. **Redisclosure:** This release does not authorize redisclosure of medical information beyond the limit of this consent. The recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 & 45 CFR Parts 160 & 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2 & 45 CFR Parts 160 & 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

5. **VALIDITY:** I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Patient: _____ Date: _____

KOHLES FAMILY PRACTICE
BRIAN KOHLES, MD
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ANDERSON, IN. 46012
(765)393-1488

*Please fax to Kohles Family Practice at 765-400-5217 or return to the office at your visit.