**Christopher Kye, MD, PA**
900 N.W. 17th Avenue, Suite 201
Delray Beach, FL 33445
Phone # 561-501-5761 Fax # 561-501-5720

# Authorization to Release Protected Health Information

I _____*(please print name)*, _____*(date of birth)*

hereby authorize Christopher Kye, MD to: _____ release information to: _____ obtain information from:

Name: _____ Relationship: _____

*Name of physician, therapist, school, hospital, individual, etc*

Address: _____

Phone number: _____ Fax number: _____

| | | | |
|---|---|---|---|
| | History and physical examination | | Radiology, EKG/EEG reports |
| | Provider progress notes | | Special procedures |
| | Medication records | | Financial account information |
| | Laboratory reports | | Other |
| | Discharge summary and instructions | | **Entire chart** |

I understand that this information may include records including alcohol or substance abuse, pregnancy, sexually transmitted diseases (STD) acquired immune deficiency syndrome (AIDS), and/or HIV status, mental health records and/or other "sensitive information"

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- For verbal and written communication about my complete medical records, including all labs, radiology reports, EKG imaging, consult reports, progress notes, and medication records.
- Remains in effect indefinitely unless otherwise specified by me
- Is voluntary and my treatment and fees are not conditional on my signing this authorization

I FURTHER UNDERSTAND:

- If I no longer want information to be shared between Dr. Kye and any of the individuals named above, I have the right to revoke this authorization at any time. I must notify Dr. Kye in writing to do so.
- Written revocation does not affect any disclosures of medical information that have already been discussed.

By signing below, I acknowledge that I have read this document in full and understand the terms of this authorization to verbally discuss my health information. All of my questions have been answered satisfactorily.

_____ _____/_____/_____

(Signature of patient, parent, or legal representative) (Today's date)

_____ (Relationship to patient)