KEVIN LEEHEY, M.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Address: _____

Phone/Fax/Email:_____

The above person, doctor, therapist, clinician, provider or agency and Dr. Leehey are authorized to communicate by phone, electronically, in person, or through records in order to assist them in providing treatment for me or my child.

The patient:

Name:_____

Date of Birth_____

_____

_____

_____

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_____

I understand that my records are protected under Federal, HIPAA, state, and other confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. I certify that this request has been made freely, voluntarily without coercion and the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by written notice. By releasing information requested Dr. Leehey is hereby released from all liability that may arise.

Date:_____ Signed_____

(patient)

Signed_____

(parent or guardian)

Witness_____

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR BY THE PARENT OR GUARDIAN IN THE CASE OF A MINOR.