Nat Kuhn MD
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Authorization to Release Medical and Mental Health Information

Your Name	First	MI	Last				
Address		Apt #		Phone	( ) -		
City		State		Zip		Birth Date	___ /___ /_____

I authorize the following person or facility to ☐ release and/or ☐ exchange medical and/or mental health information to/with Dr. Nat (Nathaniel S.) Kuhn:

Name	Person or Facility						
Address							
					Phone	( ) -	
City		State		Zip		Fax	( ) -

Information to be released (please **cross out** any options you do not wish to authorize):

General Authorization	For medical, mental health, drug/alcohol, HIV/AIDS, genetic information **or**		
Particular Information Only	Specify		
Communication Method	Verbal Information and Copies of Records		
Reason for Disclosure	☐ Evaluation and/or Treatment ☐ At my request **or**		
	Specify Other Reason		
Term of Authorization	☐ During my treatment with Dr. Kuhn **or**	Expiration Date	___ /___ /_____

Conditions of Authorization	I understand that: • I do not need to sign this authorization, in which case no information will be disclosed. • I will not be denied treatment if I choose not to sign this authorization. • I am entitled to a signed copy of this authorization. • I can revoke this authorization at any time, by written request to Dr. Kuhn. • The revocation is effective immediately on Dr. Kuhn's receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request. • Dr. Kuhn's privacy policy is available at his web site, at www.natkuhn.com/privacy
Signature	Signed: _____ Date: _____