

# MARY KELLY GREEN, MD, PLLC

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## Authorization for the Office of Mary Kelly Green, MD, PLLC to release medical information as indicated below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Release Medical Records to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

\_\_\_\_ Patient Initials

Personal Copy of Patient Records	No Charge
Includes <b>summary</b> of patient's last visit & testing if applicable	

\_\_\_\_ Patient Initials

Personal Copy of Patient Records	<b>\$25.00 for first 20 pages &amp; then \$.50 per page for every copy thereafter</b>
Includes complete copy of all patient records <i>(Patient responsible for payment)</i>	

\_\_\_\_ Patient Initials

For Continuation of Care – Sent Directly to Physician/Doctor	No Charge
Includes <b>summary</b> of patient's last visit & testing if applicable	

\_\_\_\_ Patient Initials

For Continuation of Care – Sent Directly to Physician/Doctor	<b>\$25 for first 20 pages &amp; then \$.50 per page for every copy thereafter</b>
Includes complete copy of <b>all</b> patient records <i>(Patient responsible for payment)</i>	

I agree that any information regarding drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

\_\_\_\_ Yes (Initials)    \_\_\_\_ No (Initials)

I agree that any medical billing record(s) containing information in reference to drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

\_\_\_\_ Yes (Initials)    \_\_\_\_ No (Initials)

I further authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to revoke this request. Additionally, I hold harmless Mary Kelly Green, M.D. PLLC, its agents and employees from any recourse due to any loss, claims for injury or damage, costs, expenses, neglect, or injury or damage caused by any unintentional acts or omissions.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_