Karen E Kennedy MD
1118 Gulf Breeze Parkway, Suite 201, Gulf Breeze, Florida 32561
Phone 850-916-7766 Fax 850-916-5144

Authorization for Release of Medical Information

Patient's Name: ____

Date of Birth: _________________________

Social Security Number: ___________________

Please release medical records by my authorization from and to the following offices:

From: _______________________________________

____

____

To: Karen E Kennedy MD PA
1118 Gulf Breeze Parkway, Suite 201
Gulf Breeze, Florida 32561

I authorize the release of information, including, if applicable, specific laboratory tests of HIV (Human Immunodeficiency Virus) infection or the diagnosis of Acquired Immune Deficiency Syndrome or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse, and/or alcoholism or sickle cell anemia.

Specific tests needed: All, or specify: ____________________________________

____

This authorization is valid for one year unless I revoke in writing.

Signature: ___________________________________

Date: ____