PONDWORKS
PSYCHIATRY AND PSYCHOTHERAPY

FOR OFFICE USE ONLY			
☐	Scan ONLY	☐	EXPEDITE
☐	Initial evaluation	☐	Lab records
☐	Treatment records	☐	Medications list
☐	Last 3 visit notes	☐	EKG
☐	Other _____		

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ ____/____/_____
Printed Name Date of Birth

authorize the release of medical records between **Bernard Kim, M.D.**, at the above address, and:

Name: _____

Address: _____

Phone: _____

Fax: _____

The information contained therein pertains to:
- ❑ Mental health care
- ❑ Medical care
- ❑ Substance use and treatment
- ❑ HIV status and/or testing
- ❑ Other: _____

The method(s) of release of information may include:
- ❑ Verbal communication
- ❑ Written communication
- ❑ Photocopies and/or fax
- ❑ Electronic copy or access via a web-based portal

The purpose of this release is:
- ❑ To communicate regarding treatment and coordination of care (e.g., with primary care doctor or therapist)
- ❑ For use by a third party (e.g., insurance company, lawyer)
- ❑ Other: _____

Information specifically excluded from this release, if any: _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. Unless otherwise revoked, this authorization will expire (PLEASE SELECT ONE):

- ❑ If I am no longer in treatment with a provider at Pondworks
  -OR-
- ❑ (1) year
  -OR-
- ❑ Specified length of time: _____

Signed: _____ Date: _____
(Patient or Legal Representative)

Printed Name: _____