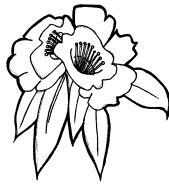


Pratistha Strong, D.O.  
**Kathmandu Clinic**  
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Kirkwood, MO 63122



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### Medical Release of Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

I authorize: \_\_\_\_\_ to release my health information to Dr. Pratistha Strong, Kathmandu Clinic.

Purpose of disclosure: \_\_\_\_\_

I specifically authorize the use or disclosure of the following health information:

\_\_\_ ALL MEDICAL RECORDS

\_\_\_ Radiology Reports \_\_\_\_\_ from \_\_\_\_\_

\_\_\_ Chart Notes ALL or from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ Labs ALL or from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ Other (please list) \_\_\_\_\_

\_\_\_ Verbal exchange of information between providers

I understand that I may revoke this authorization at any given time by giving written notice.

I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

\_\_\_\_\_ Date \_\_\_\_\_

(Signature of Patient or Patient's Legal Representative)

\_\_\_\_\_  
(Printed Name of Patient or Patient's Legal Representative)