AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Agents and/or representatives of:

_____

_____

_____

_____

Phone: _____

I, _____, hereby request and authorize the Kentucky Physicians Health Foundation to release and to receive all medical records, reports and correspondence in regard to my evaluation and/or recovery and/or treatment process either in writing or verbally to and/or from the above named individual/company.

A photocopy of this document shall be as effective as the original. This Authorization is effective for a period of sixty (60) months from the date of its execution and/or the date of contract.

_____
Signature

_____
Print Name

_____
Date

WITNESS SIGNATURE: _____ DATE: _____

ADDRESS: _____

_____

PHONE: _____