BRIAN M KAGAN MD PA
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby Authorize Dr Kagan's Office to release records pertaining to:

Name	DOB	Name	DOB
Name	DOB	Name	DOB

[ ] All records, including mental health, addiction/drug abuse and HIV status, compiled during hospitalization and/or outpatient care as well as from previous providers if applicable.

[ ] Other (Describe specifically)______________________________

Please send records to:

Name/Office: ______________________________

Fax Number: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

I understand that all records may be transferred by mail or electronically and the office is not responsible for any breach of confidentiality that may arise from the transfer of these records.

Signature: ____________________ Relationship: ____________________

Date: _______________