BRIAN M KAGAN MD PA

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Dr Kagan 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: _____

Phone Number: _____

Fax Number: _____

Street Address: _____

City, State, Zip: _____

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

_____	_____
Signature	Relationship
_____	_____
Date	Phone number