

LLOYD J. CLEAVER, D.O., L.L.C.
PO BOX 7545
KIRKSVILLE, MO 63501
PH 660-626-2191 FAX 660-626-2396

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient's name _____

Date of Birth _____ / _____ / _____

Address _____

Phone _____

I authorize Dr. Lloyd J. Cleaver to:

Obtain From Release To

THIS CONSENT IS SUBJECT TO THE FOLLOWING:

Confined to records regarding treatment for the following medical condition or injury:

_____ on or
About _____ (date)

Covering records for the period of _____ to _____

Confined to the following specified information:

- History and Physical Pathology Reports ER Records
 Consultation Reports X-Ray Reports Medication List
 Office Notes Lab Reports (specify) _____
 Other (specify) _____

I understand the Authorization may be revoked by written notice by my self at any time. Unless otherwise stated, this authorization will be if effect for one year past the date signed below. I understand that I may inspect and copy any written correspondence released to the above party. A photocopy of this authorization shall be fully effective and as valid for all purposes as the original hereof. I understand that once my PHI has been released it may not be covered under the Privacy Rule of Dr. Lloyd J. Cleaver, D.O., L.L.C.

Signature _____ Date _____

Witness _____ Date _____
