CHRISTEN M. KERR, M.D., P.C.
1307 DOLLEY MADISON BOULEVARD, SUITE 3C
McLEAN, VA 22101
Phone 703-734-7961 Fax 703-734-7962

Authorization for Christen M. Kerr, M.D., P.C. to Use or Disclose My Health Information

Patient name: _____ Date of Birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by Christen M. Kerr, M.D., P.C.

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

- ☐ Psychiatric records
- ☐ Drug abuse treatment records
- ☐ Alcohol abuse treatment records
- ☐ Psychotherapy notes
- ☐ HIV/AIDS information
- ☐ Sexually transmitted disease information
- ☐ Other

You may disclose this health information to:

Name (or title) and organization: _____

Address: _____ City_____ State _____ Zip _____

Reason(s) for this authorization (check all that apply)

- ☐ At my request
- ☐ Other (specify)

This authorization ends: ☐ On (date) _____
☐ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Christen M. Kerr, M.D. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- With written request
- With verbal request

Patient Signature: _____ Date : _____