AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION[1]

KANSAS CITY FAMILY MEDICAL CARE

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

CITY/STATE/ZIP _____

PHONE # (provide direct # where you can be reached regarding this form or where a voicemail message may be left for you)

Home_____ Cell/other_____

Disclosure of protected health information is made at my request for:

☐ Change of Insurance ☐ Referral ☐ Other_____

☐ Change of Physician ☐ Personal health records

Records to be disclosed: CHECK ONLY ONE OF THE FOLLOWING BOXES (A or B).

If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPARATE FORMS – One for Each Purpose.

☐ A. Records *except* for Psychotherapy Notes ☐ B. Psychotherapy Notes only.

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED/CHECK ALL THAT APPLY:

☐ All Records* ☐ Records from (date)_____to (date)_____

☐ Alcohol/drug evaluation or treatment ☐ Lab, x-rays and diagnostic tests only

☐ HIV/AIDS Status ☐ Other/please provide specific information _____

_____

*"All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices and information from all other health care providers used for our care and treatment in the hospital/facility).

Persons, facility, or class of persons who are authorized <u>to disclose (provide)</u> the records/information:

☐ **The facility/hospital named above**

☐ Other _____

Persons, facility, or class of persons who are authorized <u>to receive</u> the records/information:

Physician/hospital/other healthcare provider name_____

Attorney/law firm_____ **N/A** ☐

Address_____

City/State Zip_____

Phone #_____

Please complete more than one form if multiple disclosures to multiple providers are requested.

I authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by his form. I also understand that the hospital/facility will not condition treatment, payment, enrollment or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I also permit disclosure of information upon presentation of a use of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event or condition_____.

If I fail to specific an expiration date, event or condition, this authorization will expire 1 (one) year from date signed.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____

Signature of Patient (or Patient's Personal Representative, if applicable) **Date of Signature**

Personal Representative's Relationship/Capacity to Patient:_____

Printed Name of Personal Representative: _____

Printed address & telephone number of Personal Representative: _____