PLEASE DO NOT FAX IF MORE THAN 50 PAGES

Family Medicine East, Chtd
1709 S. Rock Rd
Wichita, KS 67207
Phone: (316) 682-7411 Fax: (316) 689-6688

Authorization for the Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:	Address:

I hereby authorize _____ **to use/disclose protected health information**
*(Name(s) of person or facility & address **FROM** which disclosure is to be made)*

concerning the above named patient to: _____
*(Name(s) of person or facility & address **TO** which disclosure is to be made)*

Date range of records to be released: _____

For the following purpose(s): _____

Check Type of Information Authorized to be Used and/or Disclosed

(Unless the appropriate box is checked, Family Medicine East, Chtd. will ***not*** disclose records contained in its medical records prepared by health care providers not affiliated with Family Medicine East, Chtd. unless the records were prepared on behalf of Family Medicine East, Chtd).

❑ Billing Records	❑ Emergency Room Records	❑ Operative/Procedure Reports
❑ Cardiac Studies	❑ Imaging/Radiology Reports	❑ Patient Demographic Information
❑ Consultation Reports	❑ Lab Test Results	❑ Physician Progress Notes
❑ Nursing Notes	❑ Other_____	_____

❑ Entire Record (will not include billing records or records not prepared by or on behalf of Family Medicine East, Chtd unless also selected)

❑ Records not prepared by or on behalf of Family Medicine East, Chtd. Family Medicine East, Chtd. cannot be responsible for the completeness or accuracy of such records.

This authorization shall remain in effect until_____(date) or _____(occurrence of specified event) at which time this authorization to disclose the identified health information expires. Authorization will expire 1 year from date signed if not specified.

By my initials, I understand that the record to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program _____; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately _____; information relating to HIV testing, HIV status or AIDS _____. I understand that such information is subject to special protections pursuant to law. I authorize Family Medicine East, Chtd. To use or disclose records containing such information if they are other wise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of $18.97 per request and a coping charge of .63 for the first 250 pages and .45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine, (i.e. Ultrasound images and X-rays). If records are stored off site an additional retrieval fee of $25.95 will be charged. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Family Medicine East, Chtd.'s Notice of Privacy Practice by mailing or hand delivering written notification to the following person: Privacy Officer, 1709 S. Rock Road, Wichita, KS 67207.

_____ _____
Date *Signature of Patient/Patient Representative*

_____ _____
Printed Name of Patient Representative and Relationship *Patient Representative Address and Telephone Number*

_____ _____
Date *Signature of Witness*