AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-7 must be completed. If any block is not completed, then this "Authorization Form" will be considered incomplete and defective and cannot be used.

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES

Block 1: Identification of Patient

PATIENT NAME_____DATE OF BIRTH_____SSN_____

PATIENT'S ADDRESS_____

Block 2: Type of Records/Information to be disclosed: Please describe what specific records/information may be used or disclosed. Psychotherapy notes may not be included: a separate authorization is required. (examples: ALL, X-Rays only, records for the last 12 months….)

Block 3: Persons, Facility, or class of persons who are authorized to use or disclose (provide) the records/information:

Block 4: Persons, facility or class of persons who are authorized to receive the records/information:

Health Professionals of Winfield
1230 E. Sixth Ave, Suite 1B
Winfield, KS 67156
Phone (620) 221 – 4000
Fax: (620) 221 – 7121

Block 5: Expiration: This "Authorization" will expire on_____, or on the following specific event:

Block 6: Purpose for which you wanted records/information used or disclosed:

Block 7: Authorizing Signature:

- 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 may inspect or obtain a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation.
- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. 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 Date of Signature

_____ _____

Personal Representative's Relationship to Patient Printed Name of Personal Representative