

WICHITA CLINIC, P.A.

3311 East Murdock

Wichita, KS 67208

For Medical Records:

Phone: 316-613-4995

Fax: 316-613-5371

For Radiology

Phone: 316-689-9157

Fax: 316-689-9785

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize:

(Name of physician / health care provider releasing records) To release to: (Required Information)

All Wichita Clinic Providers

Specific Physician \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Entire medical record

Entire medical record for specified date(s) of service: From: \_\_\_\_\_ To: \_\_\_\_\_

ONLY the following specific information: \_\_\_\_\_

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

- Psychological/psychiatric condition and Psychotherapy Notes • Drug and/or alcohol abuse diagnosis and/or treatment
- Genetic testing • HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: \_\_\_\_\_

The purpose of the disclosure is: \_\_\_\_\_

**The Wichita Clinic is not responsible for the accuracy or completeness of records created by other health care providers.**

**Re-disclosure of Information:** I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

**Right to Refuse to Sign this Authorization:** I understand that generally the person(s) and/or organization(s) listed above who I am authoring to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

**Right to Revoke:** I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

**Right to Inspect:** I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

**Right to Receive a Copy of Authorization:** I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

**Expiration Date:** I understand this Authorization shall expire one (1) year from date listed above unless I indicate otherwise

Noted here: \_\_\_\_\_

Per the Kansas Department of Labor: The patient or representative shall pay for the reasonable cost of obtaining a copy of his/her records including charges for labor and supplies not to exceed \$18.40 plus \$.61 per page for the first 250 pages, and \$.44 per page for every additional page. Actual postage or shipping costs also may be charged. (Note: Radiology charges are based on metro area averages. Radiology film \$8.00 per sheet.) 01/2011

Signature of Patient or Legal Representative(s): \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Printed Name(s): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ (if signed by other than patient) Phone: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

**Right to Inspect and Copy.** You have the right to inspect and copy health information maintained by the Wichita Clinic. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

**Right To Request Amendment.** If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

**Right to an Accounting of Disclosures.** You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request this list, you must complete a specific form providing information we need to process your request.

**Right to Request Restrictions.** You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific form providing information we need to process your request. The Wichita Clinic's Privacy Officer is the only person who has the authority to approve such a request.

**Right to Request Alternative Methods of Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. The Wichita Clinic's Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

## COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with the Wichita Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the Wichita Clinic, **please contact Privacy Officer, Wichita Clinic, P.A., 3311 E. Murdock, Wichita, KS 67208. All complaints must be submitted in writing. You will not be penalized for filing a complaint.**

The Wichita Clinic reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

03/10/06

Wichita Clinic Copy Service is provided by: Verisma Systems, Inc.

If you have questions, concerns or status of your request please contact Verisma customer service at 1-866-390-7404

03/09/2011