

WICHITA CLINIC, P.A.
3311 East Murdock
Wichita, KS 67208

For Medical Records:
Phone: 316-689-9577
Fax: 316-689-9635

For Radiology
Phone: 316-689-9157
Fax: 316-689-9635

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

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: _____

The following protected health care information:

Entire medical record (**NOTE:** This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is **NOT** strictly limited to records generated by the physician/health care provider indicated above.)

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 conditions
- 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: _____

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 authorizing 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 that unless I provide a written revocation at an earlier date, this authorization will expire in one year.

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 _____

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 \$17.50 plus \$.58 per page for the first 250 pages, and \$.41 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 CDs are \$25.00 per CD and \$8.00 per sheet of film.)
04/08