Axtell Clinic

MEDICAL PARK EYE CENTER

Please complete this form and sign below where indicated. Form can then be faxed to 316-283-3575.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ Check here if you are requesting copies of your own medical record and would prefer to receive them in electronic format. **Note: Email is NOT secure! This means others may intercept the email and access your health information.**

Name: **DOB:** Phone #:

Address: Email:

I hereby authorize:

Provider/Facility: **Phone #:** **Fax #:**

Address: City: State: Zip:

to disclose protected health information concerning the above named person to:

Provider/Facility: **Phone #:** **Fax #:**

Address: City: State: Zip:

☐ **Entire Record:** consists of the most recent information (up to 5 years) and may include records from other health care providers, history forms, insurance information, care providers, correspondence, etc. It is not strictly limited to records generated by the health care provider indicated above.

☐ **Medical records for specified date(s) of service:** From _____ To _____

☐ **Only the Following Specific Information:**

☐ Office Notes ☐ Lab Results ☐ Radiology ☐ Pathology ☐ Medication List

☐ Other: _____

Purpose or Need for Disclosure

☐ Transferring Patient Care ☐ Personal Use* ☐ Insurance* ☐ Attorney/Legal*

☐ Other*: _____

*Copying Fees may be associated with this request. Physician Office to Physician Office transfers are free of charge.

I understand that:

- **The information in my health record may include information relating to sexually transmitted diseases (STDs/STIs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.**
- I may withdraw this authorization at any time, by submitting a written request to ATTN: Privacy Officer at the address below.
- Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - when obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- This authorization will expire on _____ or 90 days from the date it is signed.
- Authorizing the disclosure of PHI is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment.
- I may inspect or copy the information to be disclosed as provided in CFR 126.524.
- Information release on this authorization, if re-disclosed by the recipient, is no longer protected by Axtell Clinic and may no longer be protected by HIPAA.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or facilities listed above.

Signature of Patient or Legal Representative Date

Printed Name of Patient or Legal Representative Relationship to Patient