

**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**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Address:</b>
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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): \_\_\_\_\_

<b>Check Type of Information Authorized to be Used and/or Disclosed</b>		
(Unless the appropriate box is checked, Family Medicine East, Chtd. will <b>not</b> 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).		
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Operative/Procedure Reports
<input type="checkbox"/> Cardiac Studies	<input type="checkbox"/> Imaging/Radiology Reports	<input type="checkbox"/> Patient Demographic Information
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Lab Test Results	<input type="checkbox"/> Physician Progress Notes
<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Entire Record (will not include billing records or records not prepared by or on behalf of Family Medicine East, Chtd unless also selected)		
<input type="checkbox"/> 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 Family Medicine East may charge an individual who is requesting their own PHI, or that individual's personal representative no more than a reasonable cost-based fee, which includes the cost of copying, including supplies and labor, postage and preparation of a summary or explanation if applicable. This does not include cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine, (i.e. Ultrasound images and X-rays). 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