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**AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION**

**Kansas Medical Clinic, P.A.**

**2200 SW 6th Avenue, Suite 104, Topeka, KS 66606**

**Patient Name – Please Print Date of Birth**

**Address City State Zip**

***I authorize:***

**Name of Provider or Name of Facility Address City State Zip**

To disclose the following: All information in your possession, or as designated by the attending physician, relative to my physical condition, past and present, including the diagnosis and history of my case, or such portion of it as may be requested.

**TO:**

**Name of Practice, Provider or Entity to receive information**

**Address City State Zip Phone Fax**

For the following purpose: At the request of the individual. or for specific reasons as stated below.

**This authorization will expire on:**

**(Date of event cannot exceed one year)**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such notice to the practice's Privacy Contact at Kansas Medical Clinic, except to the extent it has acted in reliance thereon before notice of such revocation.

I understand that information used or disclosed pursuant to this authorization, may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rule, 45 C.F.R. parts 160, 162, and 164.

My physician will not condition my treatment, payment, enrollment in health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure of the requested information will result in any remuneration to the above named office or hospital from a third party, a statement about such remuneration will exist in this authorization.

I understand that the records to be used or disclosed pursuant to this authorization may contain \_\_\_\_\_ records relating to participation in any federally assisted drug and alcohol abuse programs; \_\_\_\_ 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; pursuant to 45 C.F.R. 164.508; C.F.R. Part 2; KSA 65-5601 et seq: and K.S.A. 656001 *et seq*. By my initials on the line immediately prior to each of the specifically described records in this paragraph I authorize \_\_\_\_ to use or disclose records containing such information if they are otherwise included within the scope of this authorization. As to the records disclosed or used pursuant to my initials in this paragraph, I understand that these records shall not be redisclosed without my express written consent.

**understand I will receive a copy of this authorization.**



**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of Personal Representative of Patient Date:**

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**Description of Representative's Authority to Act for Patient**  **Representative’s Address and Phone Number**

**Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**