Authorization for the Use and Disclosure of Protected Health Information

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996 and state law, Family Care Clinic of Western Kansas, LLC is requesting your authorization for use or release of health information. This authorization form gives Family Care Clinic of Western Kansas, LLC your permission to acquire, use or release specified health information for treatment, payment, and health care operations, and/or research.

Please complete with Black or Blue Ink or Type:

Patient Last Name: ___________________________ ______**First Name:** _______________________________ **M.I.** ______

Patient Date of Birth: _________________**Patient Address:** ____

I hereby authorize disclosure of my health information under the following conditions and limitations:

<table>
<tr><td colspan="2">1. Information may be disclosed to:</td><td colspan="2">Family Care Clinic of Western Kansas, LLC
200 W. Ross Blvd
Dodge City, KS 67801
Phone: (620) 371-7300 Fax: (620) 371-7304</td></tr>
<tr><td colspan="2">2. Information may be disclosed by:</td><td colspan="2">Name/Entity: ____

Address: ____

____

Phone: ____________________ Fax: __________________</td></tr>
<tr><td colspan="2">3. Information to be disclosed. Check the appropriate boxes in 3(A) to authorize release of the complete medical record or itemized records.</td><td colspan="2">3(A). State type(s) of information that may be disclosed.

_____ My complete medical record(s), except for 3.1(B), or:</td></tr>
<tr><td></td><td>___ Discharge Summary
___ Emergency Room
___ History & Physical
___ Consultation Reports
___ Operative Reports
___ Rehab Services
Type: ___________
___ Laboratory Reports</td><td>___ Imaging/Radiology
___ Nursing Notes
___ Medication Records
___Psychological Records
___ Psychiatric Records
___ Progress Notes
___ Physicians Orders
___ Physician Progress Notes</td><td>___ Billing Records
___ Photographs
___ Other (specify)
____
____
____
________________________</td></tr>
<tr><td colspan="2">3.1. Initial and check box 3.1(B) to indicate whether you consent to the release of the health records described in box 3.1(B).</td><td colspan="2">3.1(B). _____ (initials) I DO [ ] or I DO NOT [ ] consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:</td></tr>
<tr><td colspan="2">4. Purpose for disclosure:</td><td colspan="2">State specific purpose for disclosure, e.g. “personal use,” “continuing care,” “changing provider.”</td></tr>
<tr><td colspan="2">5. Expiration date of authorization:</td><td colspan="2">State date of which authorization expires. If date is not provided, Family Care Clinic of Western Kansas, LLC will accept this signed form for seven (7) years from date of signature.
Research expiration date can be “none.” ___/___/_____</td></tr>
</table>

6. Authorization granted by: Signature: _____________________________ **Print Name:** ________________________

Date: ___/___/______ **Relationship to patient:** ____ **Self** _____ **Other:** _____________________________

Patient, spouse, legal representative, or beneficiary. (Patient’s spouse may authorize disclosure of the patient’s health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.

7. Witness Signature: ______________________________ **Date:** ___/___/_____

You are not required to sign this form as a part of treatment or payment. Patient or other party signing this Authorization Form has a right to receive a copy of the Authorization Form. The Authorization may be changed or revoked, in writing, to prevent disclosure of information