

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:

1. Information may be disclosed to:	Name/Entity: _____ Address: _____ _____ Phone: _____ Fax: _____					
2. Information may be disclosed by:	Family Care Clinic of Western Kansas, LLC 200 W. Ross Blvd Dodge City, KS 67801 Phone: (620) 371-7300 Fax: (620) 371-7304					
3. Information to be disclosed. Check the appropriate boxes in 3(A) to authorize release of the complete medical record or itemized records.	3(A). State type(s) of information that may be disclosed. _____ My complete medical record(s), except for 3.1(B), or:					
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;"> <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> Rehab Services Type: _____ <input type="checkbox"/> Laboratory Reports </td> <td style="width: 25%; border: none;"> <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Psychological Records <input type="checkbox"/> Psychiatric Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Physician Progress Notes </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Billing Records <input type="checkbox"/> Photographs <input type="checkbox"/> Other (specify) _____ _____ _____ </td> </tr> </table>	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> Rehab Services Type: _____ <input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Psychological Records <input type="checkbox"/> Psychiatric Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Billing Records <input type="checkbox"/> Photographs <input type="checkbox"/> Other (specify) _____ _____ _____	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;"> <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Psychological Records <input type="checkbox"/> Psychiatric Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Physician Progress Notes </td> <td style="width: 25%; border: none;"> <input type="checkbox"/> Billing Records <input type="checkbox"/> Photographs <input type="checkbox"/> Other (specify) _____ _____ _____ </td> </tr> </table>	<input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Psychological Records <input type="checkbox"/> Psychiatric Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Billing Records <input type="checkbox"/> Photographs <input type="checkbox"/> Other (specify) _____ _____ _____
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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).	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:					
4. Purpose for disclosure:	State specific purpose for disclosure, e.g. "personal use," "continuing care," "changing provider."					
5. Expiration date of authorization:	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." ____/____/____					

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