AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-7 must be completed. If any block is ***not*** completed then this "Authorization Form" will be considered incomplete and defective and cannot be used. *PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.*

Block 1: Identification of Patient

PATIENT NAME:_____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____
Street (Apt number, P.O. Box – as applicable), City, State, and Zip code

Block 2: Type of records / information to be disclosed. *CHECK ONLY ONE OF THE FOLLOWING BOXES (A or B).* If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. This authorization applies to **future** records (unless revoked) and permits persons in Block 4 to talk with persons in Block 3 about the records / information.

☐ A. Records/information except for Psychotherapy notes ☐ B. Psychotherapy notes only

DESCRIBE WHAT SPECIFIC RECORDS / INFORMATION MAY BE DISCLOSED (examples: All records. X-rays only, lab information, records for the last 12 months) and/or check all that apply: ☐ All records* ☐ Discharge Summary ☐ History and Physical

☐ Diagnostic testing, including lab and x-ray ☐ Operative Report ☐ Other _____

_____

*All records means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

Block 3: Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

☐ Kansas Spine & Specialty Hospital, LLC
3333 N Webb Road
Wichita, KS 67226

☐ Pain Center at Kansas Spine & Specialty Hospital
3223 N Webb Road
Wichita, KS 67226

Block 4: Persons, facility, or class of persons who are authorized to receive the records/information:

_____

_____

Block 5: Expiration: This "Authorization" will expire on _____ (MM/DD/YY) [In Kansas **cannot** exceed 1 year from date below] or on the following specific event: _____

Block 6: Purpose for which you want records/information disclosed: *(check one box)* ☐ At request of individual **OR**

☐ Other: *(state reason)* _____

Block 7: Authorizing Signature – I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.

I also understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization.

I also understand that I may revoke this authorization at any time by delivering/mailing a ***written*** revocation to the party or attorney or law firm named in Blocks 3 and 4 above. If I revoke this authorization it will have ***no*** affect on actions already taken on reliance of this form.

I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____
Signature of Patient or Patient's Personal Representative (if applicable) Date of Signature

Personal Representative's Relationship/Capacity to Patient: _____

Printed Name of Personal Representative: _____

Address & Telephone Number of Personal Representative: _____