COLLEGE HILL
Obstetrics & Gynecology

FAX TO 316-683-4360

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient to authorize disclosure to self or others

_____

Patient Name Social Security/Account Number

_____

Address and Phone Number Date of Birth

1. I authorize the use or disclosure of the above individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

_____

_____

_____

Address/Phone/Fax Number

3. Type and amount of information to be used/disclosed is as follows: (include dates where appropriate)

____ Entire record ____ Most recent history and physical

____ Most recent discharge summary ____ Operative report(s)

____ Laboratory results: From (date) _____ to (date) _____

____ Sonogram/X-Ray/Imaging reports: From (date) _____ to (date) _____

____ Consultation report(s)

____ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health serviced and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

College Hill OB/GYN
3233 E 2nd Street
Wichita, KS 67208

For the purpose of: _____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the address above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

(If I fail to specify an expiration date, event, or condition, the authorization will expire in 6 months)

8. I understand and agree to pay for the cost of copying the requested records.
9. I understand that authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.
10. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.
11. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
12. If I have questions about disclosure of my health information, I can contact the clinic's privacy officer.

I HAVE READ AND UNDERSTAND THE AUTHORIZATION

_____ _____

Patient or Guarantor Signature Date

_____ _____

If signed by legal rep, relationship to patient Witness