COLLEGE HILL OBGYN, P.A.
Authorization for Use and/or Disclosure of Protected Health Information

Patient Name	Birth Date	Social Security Number

1. I hereby authorize College Hill OBGYN, P.A., its employees, agents, and assigns (collectively, "College Hill") to use and/or disclose the protected health information identified in Section 3, below, as set forth herein.

2. I authorize College Hill to disclose the information identified in Section 3, below, to the following individuals:

_____
Name(s) of authorized person(s)

_____
Name(s) of authorized person(s)

3. The information which I am authorizing to be used and/or disclosed is (where applicable, identify the date of service or type of treatment):_____
_____

4. I authorize the information identified in Section 3, above, to be used and/or disclosed for the following purpose(s):

_____
If the request is initiated by the patient (or his or her personal representative) insert "at the request of patient" otherwise, describe the purpose of the use or disclosure. If the purpose relates to marketing, indicate whether College Hill will receive remuneration.

5. This authorization will expire on _____or upon the occurrence of _____.
6. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying College Hill in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Officer, 3233 East 2nd Street North, Wichita, Kansas 67208.

_____ I understand that, unless otherwise revoked, this authorization will expire upon the date or event set forth in Section 5, above.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information.

_____ _____
Date *Signature of Patient/Legal Representative*

_____ _____
Printed Name of Legal Representative *Description of Legal Representative's Relationship to Patient*

ORIGINAL — Medical File COPY — Patient