

AUTHORIZATION TO RELEASE MEDICAL RECORDS

WEST WICHITA FAMILY PHYSICIANS, P.A. · WEST WICHITA MINOR EMERGENCY OFFICE · WEST WICHITA SURGERY CENTER ·
8200 W. CENTRAL · WICHITA, KS 67212 · (316) 722-6260

AN INCOMPLETE REQUEST MAY RESULT IN DELAY OF RELEASE OF RECORDS · ALL ITEMS MUST BE COMPLETE

Patient Name: _____ Birth date: ___/___/_____ Contact phone: _____

Patient address: _____
Street City State Zip

To request records from West Wichita Family Physicians, P.A. (WWFP) I authorize WWFP, to release a copy of the requested records/patient health information concerning the above named patient to:

Name of person or place records are to be sent to

Address of where the records are to be sent to

To send records to West Wichita Family Physicians, P.A. (WWFP) I authorize the following listed below to release a copy of records (patient health information) concerning the above-named patient to WWFP:

Name of person or place records are requested from

Address of person or place records are requested from

What dates are you authorizing to be used/disclosed: All dates or Only dates ___/___/_____ To ___/___/_____

What is the purpose of the use/disclosure: Changing providers-**permanent transfer of care** yes no

Patient personal use Other _____

Record requesting to be used/disclosed: Lab Only Radiology __reports __films Billing

Entire Record (may include records not prepared by or on behalf of provider) Other _____

This authorization will expire one year from the date listed below or ___/___/_____ specific date or occurrence of specified event at which time this authorization to use or disclose the identified health information expires, but no later than **one year** from the date listed below.

Please initial _____ I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately; information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S.A. § 65-6001 et seq. By my initials, I authorize West Wichita Family Physicians, P.A. to use or disclose records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that WWFP may charge a fee for the costs of copying, mailing, or other supplies and services associated with this request. I understand WWFP may use a business associate for copying requested medical records as described in the Notice of Privacy Practices.

I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in West Wichita Family Physicians, P.A. Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Attn: Privacy Officer, 8200 W. Central Wichita, KS 67212 (316) 722-6260.

Date Signature of Patient or Patient Representative

Printed Name of Patient Representative and Relationship Patient Representative address and phone number