10600 Quivira Road, Suite 110 • Overland Park KS 66215 • 913-541-9495
1262 West Amity • Louisburg KS 66053 • 913-837-3199

Authorization for the Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:	Address:

Please Check One:
☐ I hereby authorize FOR WOMEN ONLY to obtain protected health information concerning the above named patient from:

Doctor/Practice Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone / Facsimile: ______________________________

THIS AUTHORIZATION IS FOR RELEASE OF MY ENTIRE MEDICAL RECORD

☐ Entire record (will not include billing records not prepared by or on behalf of PROVIDER unless also selected)
☐ Records not prepared by or on behalf of PROVIDER, PROVIDER cannot be responsible for the completeness or accuracy of such records.

This authorization shall remain in effect until__________ (date) or ______________________________ (occurrence of specified event) at which time this authorization to disclose the identified health information expires.

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 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 law. By my initials, I authorize PROVIDER 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 fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $15 per request, a copying charge for up to $0.52 for the 250 pages and $0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. 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 PROVIDER 'S Notice of Privacy Practices by mailing or hand-delivering written notification to the following person; [Privacy Officer @ Quivira Ste: 110 OP KS 66215].

______________________________ Date

______________________________ Signature of Patient/Patient Representative

______________________________ Printed Name of Patient Representative and Relationship

______________________________ Patient Representative Address and Telephone #

______________________________ Date

______________________________ Signature of Witness