## NORTHWEST FAMILY PHYSICIANS
## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

| Patient's Name | Birth Date | Address |
|---|---|---|
| Social Security Number | Maiden Name | |

**CHECK ONE:**

☐ I hereby authorize Northwest Family Physicians to use Protected Health Information concerning the above-named person.

☐ I hereby authorize Northwest Family Physicians to disclose PHI concerning the above-named person to:

☐ I hereby authorize ______________________ to disclose PHI concerning the above-named person to Northwest Family Physicians.

From: ______________________________

To: ______________________________

**COMPLETE THE FOLLOWING:**

For treatment date(s): ______________________________

For the following purpose(s): ______________________________

If request is initiated by the individual (or representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure.

**CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED:**

Unless the appropriate box is checked, Northwest Family Physicians will not disclose records contained in its medical records prepared by health care providers not affiliated with Northwest Family Physicians unless the records were prepared on behalf of Northwest Family Physicians.

☐ Demographic Information

☐ Progress Notes

☐ Test Results

☐ Procedure Reports

☐ Emergency Room Records

☐ Consultation Reports

☐ Billing Records

☐ Other ______________________________

☐ Hospital Admission History & Physical

☐ Hospital Discharge Summary

☐ Entire Record (will not include Billing Records or records not prepared by or on behalf of Northwest Family Physicians unless those items also are selected)

☐ Records not prepared by or on behalf of Northwest Family Physicians. Northwest Family Physicians 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, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

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 (unless this authorization pertains specifically to psychotherapy notes); _________ information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

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 of up to $0.50 for the first 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 (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Medical Records Department, Northwest Family Physicians, 3730 N. Ridge Rd., Suite 100, Wichita, KS 67205.

______________________ Date

______________________ Signature of Individual/Individual Representative

______________________ Printed Name of Representative and Relationship

______________________ Representative address and telephone number

______________________ Date

______________________ Signature of Witness

**ORIGINAL - Patient Medical Record** **Records COPY - Individual**