AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

Patient Information

First Name:_____ MI:_____ Last Name: _____

Other names used: _____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone number:_____ Email:_____

Person making request: ☐ Patient ☐ Parent/Guardian ☐ Other _____

Release

I AUTHORIZE (check all that apply):

☐ KU Wichita Center for Health Care: 8533 E 32nd St N, Wichita, KS PHONE: 316-293-2622 FAX: 855-517-9494

☐ KU Wichita Internal Medicine Midtown: 1001 N Minneapolis St, Wichita, KS PHONE: 316-293-1840 FAX: 855-487-3302

☐ KU Wichita USD 261 Haysville: 1745 W. Grand, Haysville, KS 67060 PHONE: 316-293-1842 FAX: 877-460-4467

☐ KU Wichita Psychiatry & Behavioral Sciences: 1001 N Minneapolis St / 8533 E 32nd St N, Wichita, KS
PHONE: 316-293-2647 / 316-293-3890 | FAX: 855-476-0305

TO (select one): ☐ **Release** health information to ☐ **Obtain** health information from ☐ **Exchange** information with

Name/Organization:_____

Address: _____City:_____

State: _____ Zip: _____ Secure email (optional):_____

Phone number:_____ Fax Number: _____

Purpose of Request

☐ Continued Care ☐ At the request of the individual ☐ Insurance/Disability ☐ Litigation

☐ Other (must specify): _____

Health Information

For Treatment DATES between: From:_____ (Month/Year) To:_____ (Month/Year) or ☐ ALL Dates

Select the specific type of information to be used or disclosed:

☐ Disclose my complete health record* (which does not include "Psychotherapy Notes" as defined by HIPAA)
*Including substance abuse records/information, HIV/AIDS, sexually transmitted diseases, and behavioral and mental health services.

Disclose the following:	☐ Progress Notes	☐ Alcohol and/or substance abuse records	☐ NeuroPsych Testing
	☐ Radiology Reports	☐ HIV/AIDs records	☐ Mental health records
	☐ Lab Results	☐ Genetic testing or counseling	☐ Psychological testing

☐ Other (please specify):_____

Notices

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization and that I can inspect or copy the protected health information to be used or disclosed. If medical records or correspondence from other providers was released pursuant to this form, we cannot attest to the accuracy or completeness of the information. I hereby authorize MPA to release the protected health information as specified above.

This authorization to release protected health information (PHI) **shall remain valid indefinitely while the patient is actively receiving care from the clinic**. It will **expire twelve (12) months following the earliest of the following events**: **(1)** the patient voluntarily transfers care to another provider or clinic; **(2)** the clinic formally discharges or terminates the patient from care; or **(3)** the patient has had no documented contact with the clinic for three (3) consecutive years despite reasonable and documented efforts by the clinic to re-establish communication. The patient may revoke this authorization at any time in writing, and such revocation will not affect any disclosures made prior to the clinic's receipt of the revocation. Alternatively, the patient may specify a different expiration date, event, or condition as follows: _____

_____

If the attached records contain information regarding drug and/or alcohol treatment then these records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, the prohibition on redisclosure detailed below applies, and these records cannot be disclosed without written consent unless otherwise provided for in the regulations. To the extent that the information disclosed includes information related to substance use disorder (SUD) treatment records protected by the requirements of 42 CFR Part 2, the following written statement applies: **42 CFR part 2 prohibits unauthorized use or disclosure of these records.**

Except as noted above, I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. MPA, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization. Facility Copy Charges may apply. MPA reserves the right to charge the fee schedule as set by the State of Kansas.

Signature

_____ _____
Signature of Patient, Responsible Party, or Authorized Legal Representative **Date**

_____ _____
Printed Name of Patient, Responsible Party, or Authorized Legal Representative **Relationship** to Patient