AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I,_____ hereby voluntarily authorize the disclosure of information from my record.

II. The information is to be disclosed by: And is to be provided to:

Name of Person/Organization/Facility **Ob-Gyn Associates of SW KS** **Fax:620.624.3186**	Name of Person/Organization/Facility
Address: **Po Box 2529**	Address:
City/State: **Liberal, KS 67905-2529**	City/State:

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record:

- o Entire Record
- o Only information related to (specify) _____
- o Only the period of events from _____to_____
- o Other (specify) _____
- o Psychotherapy Notes ONLY (by checking the box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- o **Alcohol/Drug Abuse Treatment/Referral**
- o **HIV/AIDS-related treatment**
- o **Sexually Transmitted Diseases**
- o **Mental Health (Psychotherapy Notes)**

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration or expiration event.

I understand that information disclosed by this authorization may be subject to rediclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 522a].

Signature of Patient	Date
Signature of Authorized Representative (State relationship to patient)	Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning any individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 522a(i)(3)).

Name (Last, First, M)	Date of Birth
Address	
City/State/Zip code	Chart Number