Authorization to Disclose Protected Health Information (PHI)

Associates in Women's Health, P.A.

Patient Name:	**Birth Date:**
Maiden or Former Name (s):	**Physician:**
Address:	**Phone #:**

Request Records From: _____

Address: _____

Records Dated From: _____ **through** _____

Records Pertaining To: _____

Purpose of the Release: _____

Expiration Date: _____

Expiration date can be no later than one year from date listed below.
If the item is left blank, the authorization shall remain effective for 60 days after the date listed below.

Send Records To: _____

Address: _____

_____

I authorize you to discuss with and disclose or prepare and furnish a report of my medical condition or conditions, including any condition or care related to drugs and/or alcohol dependency, psychiatric or psychological diagnosis, or HIV or AIDS status to any member or employee of requesting facility. Also to permit such person or persons to examine and copy any documents, records, pictures or x-rays, under your control. 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. _____

A copy or photocopy of this authorization will serve the same validity as though an original has been presented.

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 $18.97 per request, a copying charge of $0.63 per page for the first 250 pages and $0.45 per page 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, Associates in Women's Health, P.A
3232 East Murdock, Wichita, KS 67208.

_____ _____

Date Signature of Patient/Patient Representative Telephone Number

_____ _____

Printed Name of Patient Representative and Relationship Patient Representative Address and Telephone Number

_____ _____

Date Signature of Witness