

AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-7 must be completed. If any block is not completed, then this "Authorization Form" will be considered incomplete and defective and cannot be used.

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

Block 1: Identification of Patient

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

Block 2: Type of Records/Information to be Disclosed: please describe what specific records/information may be used or disclosed. Psychotherapy notes may not be included; a separate authorization is required. (examples: all, x-rays only, records for the last 12 months...)

Block 3: Persons, facility, or class of persons who are authorized to use or disclose (provide) the records/information:

Block 4: Persons, facility, or class of persons who are authorized to receive the records/information:

Sunflower Ob-Gyn, PA

1230 E. 6th Suite 2D

Winfield, KS 67156

Phone 620.222.6250

Fax 620.222.6251

Block 5: Expiration: this "Authorization" will expire on _____, or on the following specific event:

Block 6: Purpose for which you wanted records/information used or disclosed:

Block 7: Authorizing Signature

- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations
- I may inspect or obtain a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation.
- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Patient's Personal Representative

Date of Signature

Personal Representative's Relationship to Patient

Printed Name of Personal Representative