LAWRENCE FAMILY MEDICINE & OBSTETRICS
1220 Biltmore Dr. Lawrence, KS 66049

Authorization for Release of Health Information

Patient Name _____ Date of Birth_____

Previous Name_____ SS#_____ Phone #_____

Patient Address_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: This consent to release information is intended to satisfy the requirements of Kansas, Missouri and Federal Law.

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes and CONFIDENTIAL HIV* related information, unless I specify otherwise below. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information, these agencies are responsible for protecting my rights.
2. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re disclosed by the recipient (except as noted above in Item 2), and this re disclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the person, agency or medical professional specified by the patient/parent/guardian.
7. I understand that a photocopy charge will be incurred for all requests except those directed to a physician or healthcare facility.
8. ***Name and Address of health provider or entity to release this information from:***

   _____

9. ***Name and Address of provider Information will be released to:***

   _____

10. (a) Specific information to be released:
    - Medical record from (insert date) _____to (insert date)_____
    - Entire Medical Record, including patient history, office notes, Xrays, laboratory results & records sent by other health care providers

    (b) Include: ***indicate by initialing:*** Alcohol/Drug Treatment _____Mental Health _____HIV related_____

11. Reason for release of information: 11. b. Date on which Authorization will expire:_____
    - At request of individual
    - Other: _____

_____

Signature of authorized person Relationship Date