KU SCHOOL OF MEDICINE WICHITA MEDICAL PRACTICE ASSOCIATION The University of Kansas

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Person making request_____

Patient_____ DOB_____ Patient #_____

Address_____City_____State_____ Zip_____

I authorize: (Please check location)

☐ KU Wichita Center for Health Care, 8533 E. 32nd St. N., Wichita, KS 67226 Ph 316-293-2622 **FAX NUMBER 855-517-9494**
☐ KU Wichita Internal Medicine Midtown, 1001 N. Minneapolis, Wichita, KS 67214 Ph 316-293-1840 **FAX NUMBER 855-487-3302**
☐ KU Wichita Psychiatry & Psychology, 1001 N. Minneapolis, Wichita, KS 67214 Ph 316-293-2647 **FAX NUMBER 855-476-0305**

Please check one of the following:

☐ To **release** health information to ☐ To **obtain** health information from ☐ To **exchange** information with

Name/Organization_____

Address_____

City _____ State_____ ZIP_____

Telephone (with area code)_____ Fax (with area code)_____

The Specific type and Amount of information to be used or disclosed is as follows

☐ Progress Notes including_____
☐ Lab Reports for _____
☐ Radiology Reports_____
☐ Entire Medical Record* (except Psychotherapy Notes)
☐ Other (please specify) _____
☐ Educational Records ☐ Hospital Records
☐ Psychological testing completed on _____
☐ Mental health records including_____
☐ Alcohol and/or substance abuse records
☐ HIV/AIDS records
☐ Verbal Communication
☐ NeuroPsych Testing

Covering Services between _____ and _____(Insert either date(s) or "all".)

Purpose of Request

☐ Continued Care ☐ Personal* ☐ Insurance/Disability* ☐ Litigation* ☐ Other* (must specify) _____

*Including substance abuse records/information, HIV/AIDS, sexually transmitted diseases, and behavioral and mental health services.
*Facility Copy Charges may apply. MPA reserves the right to charge the fee schedule as set by the State of Kansas.

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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it by sending written notification to the MPA at the above address, and that in any event **this consent remains in effect for 12 months from date of signature or as follows** _____ (Specify alternate date, event, or condition.) 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. 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.**

Prohibition on redisclosure: Information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient **Date** **Signature of Authorized Legal Representative** **Date**

_____ _____
Witness **Date** **Printed Name of Authorized Legal Representative & Relationship**