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 õAuthorization Formö 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_____________SSN__________

PATIENTØS ADDRESS____

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 monthsí .)

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. Sixth Ave, Suite 2D
Winfield, KS 67156
Phone (620) 222 ó 6250
Fax: (620) 222 - 6251

Block 5: Expiration: This õAuthorizationö 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 patientøs personal representative.

____ ______________________
Signature of Patient or Patientøs Personal Representative Date of Signature

____ ______________________________________
Personal Representativeøs Relationship to Patient Printed Name of Personal Representative