CANCER CENTER OF KANSAS, P.A.
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	BIRTHDATE	ADDRESS

DESCRIBE THE SPECIFIC RECORDS TO BE DISCLOSED (use space below) **AND/OR CHECK ALL THAT APPLY:**

- ❑ All records. This means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).
- ❑ Alcohol/drug evaluation or treatment.
- ❑ HIV/AIDS status.

Description of records to be disclosed if box is not checked above: _____

_____

_____

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

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

This authorization will expire on _____ (MM/DD/YY) or on the following specific event _____.

If this section is left blank, the authorization shall remain effective for one year after the date listed below.

- This request for disclosure of medical records/information is made at my request for (state reason for the disclosure): _____.
- 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 also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party or attorney or law firm named in Block 4 above.
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I authorize the 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. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____

Date Signature of Patient (or Patient's Personal Representative, if applicable)

_____ _____

Printed Name of Patient Representative and Relationship Patient Representative address and telephone number