AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM:

Clay-Platte Family Medicine Clinic, PC

I, ___________________________________ born _____________, consent to and authorize ***Clay-Platte Family Medicine Clinic, PC*** to furnish to:

____

____

(Person or facility, address, city, state, zip)

the following medical records and information: ______________________________

________________________(Specify patient name, admission date or period concerned)

for the following purpose(s): ____

____ (list all purposes).

I specifically authorize the release of types of information initialed below:

_____________Alcohol and drug abuse treatment _____________Mental health

_____________HIV status or AIDS _____________Genetic Information

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: **Clay-Platte Family Medicine Clinic, PC at 5501 NW 62nd Terrace, Suite 100, Kansas City MO, 64151.**
This authorization expires on ________________ (date of event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. If medical records or correspondence from providers is provided pursuant to this authorization, Clay-Platte Family Medicine Clinic, PC cannot attest to the accuracy or completeness of the information.

I authorize the release of my records relating to: (check one):

_______Treatment rendered prior to the date this authorization is signed

_______Treatment rendered both before and after the date this authorization is signed

_______Treatment rendered only after the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulation. A photostatic copy of this authorization shall by considered as effective and valid as the original. I also understand that a photocopy charge will be incurred for all requests except those directed to a physician or health care facility.

____ , ___________________

Signature of Patient or Personal Representative Date

If Personal Representative, Relationship to Patient ___________________________

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as 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.