

AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO:
Clay-Platte Family Medicine Clinic, PC

I, _____ born _____, consent to and authorize _____ to furnish to

Clay-Platte Family Medicine Clinic, PC
5501 NW 62nd Terrace, Suite 100
Kansas City, MO 64151

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
_____ Genetic Information _____ HIV status or AIDS

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 the above address. **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 be 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.