Mid-Kansas Women's Center, PA

Authorization for Mid-Kansas Women's Center to **Receive** my information

Name: _____ DOB: _____ Phone #: _____
(Please Print)

I hereby authorize Dr. or facility: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone and/or Fax: _____

to disclose protected health information concerning the above named person to **Mid-Kansas Women's Center, PA, 9300 E. 29th Street N., Suite 201, Wichita, KS 67226. Fax # (316) 858-1880. Phone # (316) 685-1277.**

❑ Entire Record – Which consist of the most recent (to 2yrs) information and *may* include records from other health-care providers, history forms, insurance information, care providers, correspondence, etc. It is not strictly limited to records generated by the physician/health care provider indicated above.

❑ Medical records for specified date(s) of service: From: _____ to _____

Only the following specific information:

❑ Lab results ❑ OB records ❑ X-ray & Imaging Reports ❑ Operative Notes ❑ Medication List

❑ Other (please specify) _____

Purpose or Need for Disclosure:

❑ transferring patient care ❑ personal use ❑ insurance ❑ attorney/legal ❑ disability determination

❑ other (please specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein; I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider of health plan covered by federal privacy regulations, the information may be re-disclosed and is no longer protected by HIPPA regulation. I understand that fees may be charged for preparing and sending copies of records other than those requested for treatment purposes.

Should I have questions or wish to revoke this authorization, I understand I may contact the following:
Privacy Officer, Mid-Kansas Women's Center, PA, 9300 E. 29th Street N., Suite 201, Wichita, KS 67226

_____ _____
(Signature of individual/Legal Guardian/Representative) (Date)

_____ _____
(Printed Name of Legal Guardian/Representative) and (Relationship)