Axtell Clinic

Axtell Clinic, PA
700 Medical Center Drive, Suite 210
Newton, KS 67114
Tel: (316) 283-2800
Fax: (316) 283-3575

Authorization for Use or Disclosure of Protected Health Information (PHI)

SECTION 1 – Patient Demographics

First Name ______ Middle Initial ______ Last Name ______ Date of Birth ______

Name at the time of treatment (if different than above) ______

Street Adress ______ City ______ State ______ Zip ______

SECTION 2 – Identification of Entity/Persons/Class of Persons authorized to receive PHI

Release of Information FROM:

Hospital or Clinic:______
Name:______

Adress ______ City ______ State ______ Zip ______

Phone ______ Fax ______

Release Information TO:

Hospital or Clinic:______
Name:______

Adress ______ City ______ State ______ Zip ______

Phone ______ Fax ______

SECTION 3 – The purpose of this disclosure

☐Switching Providers ☐Litigation
☐Continuation of Care ☐Disability
☐Insurance ☐Other

Specify date of treatment ____/____/____ to ____/____/____

SECTION 4 – Description of information to be used or disclosed

☐**All Pertinent Records – including those listed below:**

☐Last Office Visit ☐Imaging/Radiology
☐Medication List ☐Mammogram
☐Immunizations ☐DEXA
☐Lab reports ☐Colonoscopy
☐Pap ☐Diabetic eye exam
☐ONLY the following specified information:______

SECTION 5 – Expiration

This authorization shall remain in effect until date of ______(occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If left blank**, the authorization shall remain effective for 90 days after the date listed below. Requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about genetic testing, behavioral or mental health services and treatment of alcohol and drug abuse.**

SECTION 6 – Statement of Understanding

I, undersigned, have read the above and authorize the disclosure of such health information as described.

I understand that:

- This authorization is voluntary and that I may refuse to sign it.
- Treatment is not conditioned up the execution of this authorization.
- If the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I have the right to inspect the health information I have disclosed to be used or disclosed by Authorization form.
- If I revoke this authorization, it will have no effect on disclosures already made in reliance on this Authorization.
- I may revoke this authorization at any time by providing written notice to the person listed as follows by mailing or hand delivering written notification to the following: Privacy Office, Axtell Clinic, PA, 700 Medical Center Drive, Suite 210, Newton, KS 67114
- I authorize the use or disclosure of the Protected Health Information as described. I have received a copy of this form.
- Fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request, a copying charge of up to $.63 for the first 250 pages and $.45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine.

____/____/____
Date

______
Signature of Individual or Legal Individual Representative

______
Printed Name of Legal Representative

______
Relationship

______
Telephone Number