



Authorization For Use Or Disclosure of Protected Health Information (PHI)

Instructions:

1. Sections 1-6 must be completed. If any section is not complete, this authorization will be considered incomplete and not valid.
2. Please print legibly.
3. Refer to Andover Family Medicine Notice of Privacy Practice for additional information.

Section 1 – Demographic

Patient name: _____ Birth Date: _____
Name at time of treatment: _____ Social Security #: _____
Patient Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number - Home: _____ Cell: _____ Work: _____

Section 2 – Type of access requested

_____ Copies of Records _____ Inspection of Records

Treatment dates: _____

Please describe what specific PHI may be used or disclosed:

| | | | |
|-------------------------|--------------------|----------------------|---------------------|
| _____ Progress Notes | _____ Lab | _____ Imaging | _____ Entire Record |
| _____ Medication record | _____ Nursing note | _____ Immunizations | _____ Other |
| _____ Operative Report | _____ H&P | _____ Consult Report | _____ |
| _____ Physician Orders | _____ ER Report | _____ EKG | _____ |

Section 3 – Identification of Entity Authorized to disclose PHI

I hereby authorize _____
(Facility, Covered Entity, Persons or Class of Persons) (Phone Number) (Fax Number)

(Address) (City, State, Zip Code)
to disclose medical records information and/or protected health information of the patient listed above to: **Andover Family Medicine, 105 S. Andover Rd, Suite D, Andover, KS 67002, Ph 316-7335120, Fax 316-733-1280.**

Section 4 – Expiration

This authorization shall expire upon this date: _____ (Not to exceed 1 year.)

Section 5 – Purpose

Purpose for use or disclosure: _____

Section 6 – Statements of Understanding

- I understand the potential for PHI to be redisclosed by the recipient and may no longer be protected by federal privacy rules.
- I understand that I may revoke this authorization at any time by delivering a written revocation to the Office Manager.
- If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
- I understand that I may refuse to sign this form. If I do not sign, my health care or payment for health care will not be affected.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or I am authorized to “Act on behalf of the patient as the patient’s personal representative.”
- Applicable fees may apply.

Signature of patient/legal representative: _____ Date: _____

Printed Name of representative: _____ Relationship: _____

TO BE COMPLETED BY OFFICE STAFF

I.D. verified by: _____ Date: _____

Information sent by: _____ Date: _____