



Andover Family Medicine
105 S. Andover Rd. Suite D
Andover, KS 67002

Permission to Disclose Information For Care & Notification Purposes

By my signature below, I (or my guardian/legal representative) authorize Andover Family Medicine and its authorized representative(s) to disclose the following Protected Health Information to those persons I have designated as being involved in my health care.

- | | |
|---|--|
| <input type="checkbox"/> Appointment Times & Dates | <input type="checkbox"/> Billing & Payment Information |
| <input type="checkbox"/> Test that have been performed | <input type="checkbox"/> Tests to be performed |
| <input type="checkbox"/> Test Results | <input type="checkbox"/> Plans of Care |
| <input type="checkbox"/> Information regarding Medications | |
| <input type="checkbox"/> All information <u>except</u> that listed below: | |
| _____ | |
| _____ | |

I have reviewed the above information and do not wish to designate anyone at this time.

The Protected Health Information identified above may be released to those individuals listed below:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand this authorization will remain in effect until specifically withdrawn by me or the authorized representative signing this form.

_____	_____
Patient Name (Printed)	D.O.B.
_____	_____
Patient (Legal Guardian) Signature	Relationship
_____	_____
Date	