



**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**All sections of this authorization MUST be completed to be considered valid in accordance with 42 CFR Parts 160 and 164**

**Patient Information:**

Last Name:	First Name:	MI:	Date of Birth:
Patient Name at time of treatment (if different)		Social Security Number:	
Address:	City:	State:	Zip Code:
Phone Number: (        )		Email Address (Optional):	

**I request my Protected Health Information to be released from:**

Organization/Name: _____	Attn: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone Number: (        )	Fax Number: (        )

**I request my Protected Health Information to be released to:**

Organization/Name: _____	Attn: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone Number: (        )	Fax Number: (        )
Date of Next appointment*: _____	

\*Please allow at least fourteen business days processing time before next appointment.

**I request the following Protected Health Information to be released from my medical record(s):**

<input type="checkbox"/> Weight Loss Clinic Notes	<input type="checkbox"/> History & Physical(s)	<input type="checkbox"/> Radiology Report(s) (X-Ray, MRI, etc.)
<input type="checkbox"/> Pain Clinic Notes	<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> Radiology film/media on disc (\$15 fee may apply)
<input type="checkbox"/> Orthopedic Clinic Notes	<input type="checkbox"/> Laboratory and EKG Report(s)	<input type="checkbox"/> Other (specify)
<b>Covering periods of healthcare from: Start Date: _____ to &amp; including End Date: _____</b>		

**Purpose of this request:**

<input type="checkbox"/> Continued Care / Coordination of Care	<input type="checkbox"/> Insurance, Disability or Legal**	<input type="checkbox"/> Personal Use**
<b>** We reserve the right to charge the fees set by the State of Kansas K.S.A. 65-4971(b)</b>		

**Signature: By signing this authorization form, I understand that:**

- **Requests for copies of medical records and/or non-document material may be subject to copying fees.**
- Protected health information (PHI) may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I authorize the release of these records.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form, unless the treatment is for the sole purpose for disclosure to a third party.
- This authorization is voluntary and I have the right to refuse to sign it. I have the right to revoke this authorization at any time. Revocation must be made in writing by notifying the original recipient of this authorization. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: \_\_\_\_\_  
If I fail to specify an expiration date/event/condition, this authorization will expire 180 days from the date of authorization.

\_\_\_\_\_  
Signature of PATIENT or AUTHORIZED REPRESENTATIVE\*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE OF AUTHORIZATION

\_\_\_\_\_  
PRINTED name of AUTHORIZED REPRESENTATIVE\*

\_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S relationship to patient

\*If signed by a patient authorized representative, supporting legal documentation must accompany this authorization form.

**Return completed authorization to:**  
Blue Valley Hospital – Health Information Management  
12850 Metcalf Ave., Overland Park, KS 66213

**Phone:** (913) 387-0090  
**Secure Fax:** (913) 378-1313  
**Attach Signed Authorization to E-Mail:** [ciox@moreoflife.com](mailto:ciox@moreoflife.com)