Medical Records Release

Name_____D.O.B._____Phone_____
(Print)

Records to be disclosed from: _____

(Address) _____

(Phone) _____

(Fax) _____

Description of Medical Records to be released : _____

Records to be sent to: _____

(Address) _____
_____

(Phone) _____

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my signature, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

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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 or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $15 per request, a copying charge of up $0.50 for the first 250 pages and $0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time (expect to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Privacy Officer, Ark City Clinic, P.A., 510 W. Radio Lane, Arkansas City, Kansas 67005.

******This release expires 90 days after date signed******

_____

Date Signature of Patient or Patient Representative

_____ _____

Printed Name of Patient Representative Relationship to Patient

_____ _____ _____

Date Witness - Print Name Witness - Signature