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Authorization for the Disclosure of Protected Health Information

Patient Information:

Name: ______________________________________ Date of Birth: ___________

Address: ____________________________________ City: __________________

State: ___________________ Zip: ___________ Phone #: ___________________

I hereby authorize:

Persons or Organization: ____

Address: ____City: _________________

State: _______________________ Zip: _______________ Phone #: ______________________

To disclose or release to the following Persons or Organization listed below:

Person or Organization: ____

Address: ____ City: _________________

State: ______________________ Zip: _______________ Phone #: _______________________

Information being requested:

Specify the dates or time period when known: from: _________________ to: ________________

Clinic Notes, Lab & Test results

Confined to the following specified information: __________________________________

Purpose or need for disclosure:

Continuation of Care   Insurance Application   Legal   Personal   Other

Please note the following:

You have the right to revoke this authorization at any time by notifying the Medical Records Department of Foot Specialists of Kansas City in writing. The revocation will be effective on the date notified and will not apply to all information that has already been released in response to this authorization. This authorization is valid for a year unless specified: ________________

We may deny access to protected health information in certain situations and conditions. If you are denied access to any portion of the protected health information requested, we will notify you in writing of the reason for denial. We will also inform you of any rights you may have to have the denial reviewed. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed. Copies of records may be obtained with a reasonable notice and payment of copying services.

Please allow up to 30 days to process this request

Signature of Patient: ____ Date: ___________

Shawnee Office
9119 W. 74th St, Ste. 352
Tel: (913) 677-3600
Fax: (913) 432-7624

Blue Springs Office
1956 Copper Oaks Cir.
Tel: (816) 228-6995
Fax: (816) 228-8672

Olathe Office
153 W. 151st St, Ste. 320
Tel: (913) 829-6800
Fax: (913) 829-6197