MID-KANSAS PEDIATRIC ASSOCIATES P.A.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____

Name of Patient (Please print) Date of Birth

Is patient transferring care out of Mid-Kansas Pediatric Associates? ☐ YES ☐ NO

I hearby authorize transfer/release of records:

To: _____ From: _____

_____ _____

_____ _____

_____ _____

PLEASE MAIL IF OVER 10 PAGES

For the following purpose(s) _____

If the request is initiated by the patient or the patient's representative, state "at the request of the patient". If the purpose relates to marketing, indicate whether Mid-Kansas Pediatric Associates will receive remuneration.

If changing physicians, please indicate reason for the change

_____ Moving	_____ Office Staff	_____ Physician
_____ Insurance change	_____ Receptionists	_____ Medical Care
_____ Office location	_____ Medical Assistant	_____ Availability
_____ Child's Age	_____ Nurse	
_____ Appointment scheduling	_____ Nurse Practitioner	
_____ Time Spent in Waiting Room	_____ Other _____	

Please check the type of information authorized to be disclosed.

_____ Entire Record (will not include Billing Records or records not prepared by Provider)
_____ Immunizations
_____ Most Recent History & Physical
_____ Laboratory Results _____ X-ray Reports
_____ Other (please specify) _____
_____ For treatment date(s) _____

I understand:

- That the information in my health record may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), psychiatric care, or treatment for alcohol and/or drug abuse unless I specifically state here that this information cannot be released.
  _____
- I may revoke this authorization at any time by delivering such revocation in writing to the following person: Attn: Privacy Officer, 9825 Shannon Woods, Wichita, KS 67226. I understand this revocation will not apply to information that has already been disclosed in response to this authorization prior to my written revocation.
- That authorizing the disclosure of this health information is voluntary and that I may inspect or copy the protected health information to be used or disclosed under this authorization. I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
- That a fee may be charged for preparing and sending copies of records and agree to pay a reasonable copying fee to cover the cost of transfer.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If left blank, this authorization will expire 60 days from the date of signing.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Printed Name of Patient Representative and Relationship to Patient Signature of Witness

Prohibition on redisclosure: This information has been disclosed to you from confidential records protected by Federal Confidentiality Regulations (42 CFR Part 2). The Federal Regulations prohibit you from making any further disclosure of this information unless further disclosure if expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is *not* sufficient for this purpose. The Federal Regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.