Health Partnership CLINIC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification (PLEASE PRINT)

Name: _____ Date of Birth_____ SSN_____

Address _____ City_____ State____ Zip _____ Phone _____

I hereby authorize Health Partnership Clinic: 407 S Clairborne Rd. Ste. 104, Olathe, KS 66062
Phone: 913-648-2266/913-730-3687 Fax: 855-999-9135/855-348-3430 *www.hpcjc.org*

To release to _____ **OR** **To obtain from_____**
(Please check one)

_____ Myself (At the above listed address)

_____ _____
Name of Physician, Provider, or Organization Phone Fax

_____
Mailing Address City State Zip

Information To Be Released – Covering the Periods of Health Care

From:_____(date) To:_____(date)

Please check type of information to be released:

_____ Medical Office Notes
_____ Diagnostic Testing Reports
_____ Behavioral Health Notes
_____ Dental Office Notes
_____ Hospital Inpatient Reports
_____ Hospital ER Reports
_____ Medication List
_____ Other _____

Purpose of Request (*Please check all that apply)*

_____Treatment or Consultation _____At the Request of the Patient _____Billing or Claims Payment

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Release and Re-Disclosure

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release. (CFR 42 Part 2) I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatment or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Health Partnership Clinic to use and disclose the protected health information specified above. (CFR 42 Part 2)

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. Unless revoked, this authorization will expire on the following date or event _____ (Date), or one year from date of signature, unless otherwise specified.

_____ _____
Patient, Parent of Minor Child or Guardian Signature Print Patient Name Date

Identity of Requestor Verified via: _____ Photo ID, Matching Signature _____ Other(Specify)_____

_____
Witness of Patient's Consent / Verifier of Identity Print Name of Witness / Verifier Date