KANSAS ORTHOPAEDIC CENTER, P.A. (KOC)
7550 W. Village Circle, Suite 1 • Wichita, KS 67205-9364
2450 N. Woodlawn Blvd, Wichita, KS 67220
101 E. Fulton St, Garden City, KS 67846
316-838-2020 Office • 316-838-7574 Fax

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

PATIENT'S NAME	CHART#	BIRTH DATE	SOCIAL SECURITY NUMBER
Address			
☐ Mail to the above address CHECK ONE: ☐ I hereby authorize KOC to use PHI conce	erning the above-1	·	atient at to pick up
☐ I hereby authorize KOC to disclose PHI of	· ·	•	to:
·		•	
Name and Mailing Address of person(s)/organizate ☐ I hereby authorize		sclose PHI concer	ning the above-named person to KOC.
COMPLETE THE FOLLOWING:			
For treatment date(s):			
For the following purpose(s):	ntative), insert "at t	he request of individ	lual;" otherwise, describe purpose of the use or disclosure.
CHECK TYPE OF INFORMATION Unless the appropriate box is checked, KOC with KOC unless the records were prepared on	vill not disclose reco behalf of KOC.	ords contained in its	AND/OR DISCLOSED: medical records prepared by health care providers not affiliated
☐ Demographic Information	☐ Itemized b	illing statement	☐ Entire Record (this will not include Billing Records, X-rays or records not prepared by or on behalf
☐ Office Notes	☐ Radiology	Imaging CD	of KOC unless those items also are selected)
☐ KOC Testing Reports(EMG, MRI) (tests performed at KOC) ☐ KOC Therapy Notes	or FMLA F your office	Term Disability forms (this may includ notes and last work sta	(such as Operative Reports, Labs, EKG, outside MRI, outside PT/OT Consults etc.) KOC cannot be
We aim to process this request within 7-10 business de	ays, but it could take	up to 30 days pendin	records.
This authorization shall remain in effect unt	til	(date) or	records. g the volume of requests and availability of the information requested. (occurrence of
This authorization shall remain in effect unt specified event) at which time this authorization	tiltion to disclose th	(date) or the identified health	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the
This authorization shall remain in effect und specified event) at which time this authorizated date listed below. If this item is left blank, the	tiltion to disclose the authorization sha	(date) or ne identified health all remain effective	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the e for 60 days after the date listed below.
This authorization shall remain in effect unt specified event) at which time this authorizat date listed below. If this item is left blank , the I understand that the records to be used or disc	tiltion to disclose the authorization sha	(date) or the identified health this authorization	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the e for 60 days after the date listed below. may contain records relating to participation
This authorization shall remain in effect unt specified event) at which time this authorizat date listed below. If this item is left blank, the I understand that the records to be used or disc in any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional control of the specific product of the	til	(date) or ne identified health all remain effective this authorization infinitials n notes recorded b	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the coron for for 60 days after the date listed below. may contain records relating to participation ormation relating to diagnosis and treatment of mental, by a mental health professional documenting or analyzing
This authorization shall remain in effect unt specified event) at which time this authorizat date listed below. If this item is left blank, the I understand that the records to be used or disc in any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional conconversation during a counseling session pro	tiltion to disclose the authorization shadelosed pursuant to abuse program;ndition, other that wided such notes	(date) or ne identified health the identified health the identified health this authorization infinitials in notes recorded the are maintained see	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the exportance for 60 days after the date listed below. may contain records relating to participation ormation relating to diagnosis and treatment of mental,
This authorization shall remain in effect und specified event) at which time this authorizate date listed below. If this item is left blank, the I understand that the records to be used or disc in any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional conconversation during a counseling session propsychotherapy notes); information in the information of the protection of	tiltion to disclose the authorization shall be authorization shall be authorization shall be authorized pursuant to abuse program; ndition, other that wided such notes ation relating to he and federal laws	(date) or the identified health health the identified health health the identified health	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the coron for food days after the date listed below. may contain records relating to participation ormation relating to diagnosis and treatment of mental, by a mental health professional documenting or analyzing apparately (unless this authorization pertains specifically to status, or AIDS. I understand that such information is By my initials, I authorize the use or disclosure of records
This authorization shall remain in effect unterspecified event) at which time this authorizated date listed below. If this item is left blank, the I understand that the records to be used or discoin any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional conconversation during a counseling session propsychotherapy notes); information in they are otherw. I understand that treatment is not condition receives the information is not a health care above may be re-disclosed and no longer procopies of records, including a charge for laboration to the routinely duplicated on a standard (316) 838-2020. I understand that I may rev	tion to disclose the authorization shadlessed pursuant to abuse program;	(date) or the identified health that remain effective this authorization information in the scope of this authorizations. It is and regulations. It is and regulations. It is a copying charge, thine. For question at any time (dated)	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the coron for food days after the date listed below. may contain records relating to participation ormation relating to diagnosis and treatment of mental, by a mental health professional documenting or analyzing apparately (unless this authorization pertains specifically to status, or AIDS. I understand that such information is By my initials, I authorize the use or disclosure of records
This authorization shall remain in effect unterpreted by the specified event) at which time this authorizated date listed below. If this item is left blank, the I understand that the records to be used or disconnected in any federally assisted drug and alcohol and alcoholic, drug dependency, or emotional conconversation during a counseling session prophychotherapy notes); information in they are otherwork in the special protections pursuant to state containing such information if they are otherwork I understand that treatment is not condition receives the information is not a health care above may be re-disclosed and no longer procopies of records, including a charge for laboration to the routinely duplicated on a standard (316) 838-2020. I understand that I may revupon it) by mailing or hand-delivering written	tion to disclose the authorization shall be authorization shall be authorization shall be authorization shall be authorization, other that avided such notes at a strength of the and federal laws wise included with the authorization relating to the authorization to a strength of the authorization to strength of the authorization	(date) or the identified health that remain effective this authorization information in the scope of this authorizations. I under the copying charge, thine. For question at any time (the following personne in the following personne in the scope of this authorizations. I under the copying charge, the following personne identification at any time (the following personne identified the following personne identified the identi	records. g the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the expression for food days after the date listed below. may contain records relating to participation initials ormation relating to diagnosis and treatment of mental, by a mental health professional documenting or an alyzing exparately (unless this authorization pertains specifically to status, or AIDS. I understand that such information is By my initials, I authorize the use or disclosure of records a authorization. I understand that if the person or entity that by federal privacy regulations, the information described restand that fees may be charged for preparing and sending and the reasonable cost of all duplications of records that one regarding fees, contact Kansas Orthopaedic Center at except to the extent that action has been taken in reliance
This authorization shall remain in effect unterpreted by specified event) at which time this authorizated date listed below. If this item is left blank, the I understand that the records to be used or discoin any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional conconversation during a counseling session prophychotherapy notes); information in they are otherwall understand that treatment is not condition receives the information is not a health care above may be re-disclosed and no longer procopies of records, including a charge for laboration to the routinely duplicated on a standard (316) 838-2020. I understand that I may revupon it) by mailing or hand-delivering writte Village Circle, Suite 1, Wichita, KS, 67205.	tion to disclose the authorization shadlessed pursuant to abuse program;	(date) or the identified health that remain effective this authorization information in the scope of this authorizations. I under the copying charge, thine. For question at any time (the following personne in the following personne in the scope of this authorizations. I under the copying charge, the following personne identification at any time (the following personne identified the following personne identified the identi	records. In the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the expression of the for 60 days after the date listed below. In the procession of the information expires, but no later than one year from the expression of the for 60 days after the date listed below. In the procession of the information is the procession of the information of the information of the procession of the information of the information is the procession of the information of the information. In the procession of the procession of the information
This authorization shall remain in effect und specified event) at which time this authorizated date listed below. If this item is left blank, the I understand that the records to be used or disc in any federally assisted drug and alcohol a alcoholic, drug dependency, or emotional conconversation during a counseling session propsychotherapy notes); information in they are otherw. I understand that treatment is not condition receives the information if they are otherw. I understand that treatment is not condition receives the information is not a health care above may be re-disclosed and no longer procopies of records, including a charge for laboration to be routinely duplicated on a standard (316) 838-2020. I understand that I may revupon it) by mailing or hand-delivering writte Village Circle, Suite 1, Wichita, KS, 67205. Date Signature of Individual Printed Name of Representative and Relationship Signature of Witness Signature Signature of Witness Signature Sign	tion to disclose the authorization shadlessed pursuant to abuse program;	(date) or the identified health that remain effective this authorization information in the scope of this authorization. It has been covered by the scope of this authorization of this authorization. I under a copying charge, thine. For question at any time (the following personal to the following personal transport of the scope of the scope of this authorized the scope of the scope of the scope of this authorized the scope of the scope of this authorized the scope of t	records. In the volume of requests and availability of the information requested. (occurrence of a information expires, but no later than one year from the expression of the for 60 days after the date listed below. In the procession of the information expires, but no later than one year from the expression of the for 60 days after the date listed below. In the procession of the information is the procession of the information of the information of the procession of the information of the information is the procession of the information of the information. In the procession of the procession of the information

Revised 6-6-14

Date/Initial request received Date/Initial completed by MR