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 ❑ Call patient at _____ to pick up

CHECK ONE :

❑ I hereby authorize KOC to use PHI concerning the above-named person.

❑ I hereby authorize KOC to disclose PHI concerning the above-named person to: _____

_____.
Name and Mailing Address of person(s)/organization(s)

❑ I hereby authorize _____to disclose PHI concerning the above-named person to KOC.

COMPLETE THE FOLLOWING:

For treatment date(s): _____

For the following purpose(s):_____
If request is initiated by the individual (or representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED:

Unless the appropriate box is checked, KOC will not disclose records contained in its medical records prepared by health care providers not affiliated with KOC unless the records were prepared on behalf of KOC.

❑ Demographic Information
❑ Office Notes
❑ KOC Testing Reports(EMG, MRI) (tests performed at KOC)
❑ KOC Therapy Notes
❑ Itemized billing statement
❑ Radiology Imaging CD
❑ Short/Long Term Disability or FMLA Forms (*this may include your office notes and last work status*)
❑ Other _____
❑ Entire Record (this will not include Billing Records, X-rays or records not prepared by or on behalf of KOC unless those items also are selected)
❑ Records not prepared by or on behalf of KOC (such as Operative Reports, Labs, EKG, outside MRI, outside PT/OT, Consults, etc.). KOC cannot be responsible for the completeness or accuracy of such records.

We aim to process this request within 7-10 business days, but it could take up to 30 days pending the volume of requests and availability of the information requested.

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. **If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.**

I understand that the records to be used or disclosed pursuant to this authorization may contain _____ (initials) records relating to participation in any federally assisted drug and alcohol abuse program; _____ (initials) 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); _____ (initials) 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 initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

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, a copying charge, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. For questions regarding fees, contact Kansas Orthopaedic Center at (316) 838-2020. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Medical Information Services Coordinator, 7550 W. Village Circle, Suite 1, Wichita, KS, 67205.

_____ _____ _____
Date *Signature of Individual/Individual Representative* *Date needed by*

_____ _____
Printed Name of Representative and Relationship *Representative address and telephone number*

_____ _____
Date *Signature of Witness*

ORIGINAL – Patient Medical Record COPY – Individual

Revised 6-6-14

Date/Initial request received _____

Date/Initial completed by MR _____