Authorization for Obtaining and Disclosing of Patient Health Information

Printed Patient Name:_____

Date of Birth:_____

Requesting Provider:_____

Provider we are requesting from:_____
(Name, Address, and Phone Number of Provider/Facility)

- **I authorize Midwest Medical Specialists, P.A., "MMS"**, to obtain and/or disclose the following health information from my medical record: _____
(Describe Information, including dates of service, types of conditions or all records)
- I specifically authorize MMS to disclose the types of information selected below:

  ____ Information relating to care and treatment for *Mental Health Conditions*

  ____ Information relating to care and treatment for *Drug and/or Alcohol Abuse*

  ____ Information relating to *HIV Testing, Infection Status, or Care for HIV/AIDS*

  ____ Information relating to *genetic testing*

- The disclosure is for the purpose of:_____
(If no purpose is stated, the disclosure is made at my request)
- This authorization expires on the following date or event:_____
(If left blank the authorization will expire one (1) year from the date signed)
- I understand that I have the right to revoke this authorization at any time, except to the extent that MMS has already acted in reliance of this authorization. I may revoke this authorization by submitting my revocation in writing to MMS at the stated address.
- I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be subject to protection under MMS's policies and procedures or federal laws protecting the privacy of patient's health information.
- I understand that MMS does not condition my treatment on my signing this authorization and that I may refuse to sign this authorization. However, if MMS is providing healthcare solely to create information for disclosure to the third-party named above, MMS will not provide healthcare unless I sign this authorization.

Patient Signature: _____ **Date: _____**

If someone other than the patient signs this authorization:

Printed Name:_____ Relationship to Patient:_____

Legal Guardian:____ Parent:____ POA:____ Other (Please Specify):_____

Please return to Midwest Medical Specialists, P.A., Attn: Medical Records Department
Gateway Medical Building 7450 Kessler St., Suite 130 Merriam, Kansas 66204
Phone: 816-454-0666 Fax: 816-559-7118