Clifton Family Medicine
201 S Hillside St • Wichita, KS 67211 • Phone 316-682-6551 • Fax 316-682-8151

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____DOB:_____

PATIENT ADDRESS:_____PHONE:_____

1. Information described below will be sent **FROM:**

_____
(Name)

_____
(Address)

Information described below will be sent **TO:**

_____
(Name)

_____
(Address)

2. Purpose of requested disclosure:_____

3. Treatment dates covered by this authorization:_____

4. TYPES OF PHI TO BE DISCLOSED:
   - ❑ Progress Notes
   - ❑ Correspondence
   - ❑ Other_____
   - ❑ Psychotherapy Notes
   - ❑ Laboratory / Radiology Results
   - ❑ Billing Records
   - ❑ Entire WFMS Record

5. This authorization will end on the following date: _____ (or 1 year from date listed below, whichever occurs first.)

6. I understand I may revoke this authorization at any time by providing written notice to the Privacy Officer at CFM. I understand I may not revoke this authorization for any actions taken prior to the Privacy Officer's receipt of my written notice to revoke this authorization.
   I understand the information below is subject to special protections under federal and state laws. I am authorizing this disclosure of this information and understand my records may contain (1) PHI relating to participation in a federally- assisted drug and alcohol abuse program (2) information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting conversations during counseling sessions and such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes) (3) information relating to HIV testing, HIV status or AIDS.
   I further understand that treatment will not be conditioned upon the signing of this authorization. I understand that if the person or entity that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand fees may be charged for the preparing/sending of copies of records:

   $18.97 per request for labor and supplies
   $ .63 per page for the first 250 pages
   $ .45 per page for pages above 250

   I understand 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: **Privacy Office, Clifton Family Medicine, 201 S Hillside St, Wichita, KS, 67211.**

_____ _____
SIGNATURE OF INDIVIDUAL OR INDIVIDUAL REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF INDIVIDUAL OR INDIVIDUAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE