Office Use Only: Chart # _____

□ JEB □ CDB □ KAM □ CWP □ JCC

ORTHOPAEDIC & SPORTS MEDICINE CLINIC OF KANSAS CITY, P.A.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, date of birth_____, consent to and authorize
(Print name)

the Orthopaedic & Sports Medicine Clinic of Kansas City, P.A. to furnish to

_____
(Name of person or facility, address, city, state, zip.)

the following medical records and information: (please specify if x-rays are being

requested and which body part)_____

_____
(Specify patient name, admission date or period concerned)

for the following purpose:_____

I specifically authorize the release of types of information initialed below:

_____Alcohol and drug abuse treatment
_____HIV status or AIDS
_____Mental Health
_____Genetic Information

I understand this authorization may be revoked in writing at any time except already acted upon. To revoke this authorization I must send a request in writing to : Orthopaedic & Sports Medicine Clinic of Kansas City, P.A. Attn: Medical Records Clerk , at 3651 College Blvd. Suite 100A, Leawood, Ks 66211. This authorization expires on _____
(date or event) or within one (1) year of the date signed if I have not provided an expiration date or event.

I authorize the release of my records: (check one)

_____Only records originated prior to today's date (not including today's date).
_____Records originated both before and after today's date (including today's date).
_____Records originated only after today's date (including today's date).

I understand that my information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by the Privacy Regulations. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient or Authorized Representative Date

If Authorized Representative, Relationship to Patient:_____

_____
Witness Date

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.