AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

[Note: Release of substance abuse, mental health information or HIV status requires a separate authorization]

TO: GIBSON WATSON MARINO LLC
301 N. Main, Suite 1300
Wichita, KS 670202

PATIENT: _____
DATE OF BIRTH: _____
SSN: _____ **Phone:** _____
ADDRESS: _____

[Note: 45 CFR 164.508(c)(1)(ii)& (iii) Permit naming classes or categories of persons or entities.]

Authorization: I hereby authorize you to provide and disclose the requested Protected Health Information (PHI) to:

_____ _____ _____ _____
Name Address Phone Fax

Purpose of Disclosure _____

Information Requested: (check where applicable)

- □ **Complete Medical Records** (See definition below) **for Dates of Service**: from _____ to _____
- □ **Portion of Medical Records:** _____
- □ **Psychotherapy Records for Dates of Service**:
- □ **Substance Abuse Treatment Records for Dates of Service**: from _____ to _____ See Below
- □ **Including Secondary Records** (See definition below)
- □ **Itemized Billing Statement** listing all charges for services rendered from _____ to _____
- □ **Radiographic Films**, including x-rays, MRIs, CT scans, sonograms, ultrasound, etc. taken on or after 11/1/2009. Specific type of record requested: _____
- □ **Photographs or Video Tapes,** taken on or after _____
- □ **Special Requests/Instructions**: _____
- □ **Attorney Conference and/or Report** *[check only if authorizing conference with person named above]*

Definitions: For purposes of this authorization and release, the term "**Medical Records**" includes all records pertaining to the examination, diagnosis, care and treatment of the patient, including but not limited to: patient intake and registration forms; patient insurance and identification information; office narratives; progress notes; prescription orders; lab results; nurse and physician assistant notes; consultation reports; order sheets; handwritten notes; and, radiological and laboratory reports.

For purposes of this authorization and release, the term "**Secondary Records**" includes patient questionnaires; phone message slips; correspondence with patient; and all documents contained in the patient's office chart from other healthcare providers, insurance representatives; attorneys or government agencies, including but not limited to: medical records as defined above and all correspondence and hospitalization records.

Expiration:

This authorization shall expire on the following date (not exceeding one year) or event: _____
[NOTE: A DATE OR EVENT MUST BE SPECIFIED]

Statements of Understanding:

- I authorize you to meet and consult with the above-named party concerning any aspect of my medical condition if applicable per above.
- I understand that state and federal law (including HIPAA) may protect certain records and I am requesting that any and all such protected records be disclosed under this authorization. If the person or entity that receives my records is not a healthcare provider or health plan covered by federal privacy regulations, the records/information may be re-disclosed and may no longer be protected by those regulations.
- I understand I do not have to sign this authorization as a condition of treatment or payment by my health plan.
- I understand I may revoke this authorization at any time by written request to the Medical Records Department or the requestor/attorney. My revocation will have no effect on actions taken in reliance on this form prior to the revocation.
- I further understand that there may be reasonable charges to the requestor associated with complying with the requests herein and the requestor is responsible for payment of those charges.
- A photocopy of this authorization shall have the same force and effect as the original.

_____
Signature of Patient or Patient's Personal Representative Date of Signature

_____
Representative's Printed Name Legal Capacity Address Phone

*__Substance Abuse Treatment Records__ are confidential and protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except by with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute a patient.

ALL ELEMENTS OF THIS DOCUMENT MUST BE FILLED OUT COMPLETELY