Ann Hentzen Page, M.D.
Kathryn E. Sawchak, M.D.

1818 East 23rd Avenue
Hutchinson, KS 67502

620-662-2229
888-662-2224
FAX: 620-669-2394

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________ SSN: ______________

Address: ______________________________ City: ______________ State/Zip: ______________

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Provider or Facility: **THE WOMAN'S PLACE**

Address: **1818 E. 23RD AVENUE** City: **HUTCHINSON** State/Zip: **KS 67502**

The information to be disclosed is as follows (please check the information you want released):

	Recent GYN Visit		Pap Smear(s)		Bone Density Scan(s)
	Lab work		Pelvic Sonogram(s)		Operative Note(s)
	Mammogram(s)		OB Records		Complete Health Record From: _________To: _______
	Immunization Record		Other:		

Treatment Date(s): ____ (Please list date range or specific date of service)

Purpose of Disclosure: ☐ Share information with other providers involved in my care ☐ Transfer of care ☐ Personal use/copy

☐ Ongoing access to information when requested ☐ Other: ________________________________

I specifically authorize the release of the type of information **INITIALED** below:

	Alcohol and drug abuse treatment		HIV Status or AIDS
	Mental Health		Genetic Information

This information may be disclosed to and used by the following individual or organization:

Name:____

Address: ______________________________ City: ______________ State/Zip: ______________

Phone Number: ______________________________ Fax Number: ______________________________

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: Human Resources, HIPAA Privacy Officer, at The Woman's Place, P.A. 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 understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

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

☐ Treatment rendered **prior** to the date this authorization is signed

☐ Treatment rendered **both before and after** the date this authorization is signed

☐ Treatment rendered **only after** the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulations. A photo static copy of this authorization shall be considered as effective and valid as the original authorization. I also understand fees may be charged for preparing and sending copies of records including charge for labor and supplies up to $18.97 per request, a copying charge up to $0.63 for the first 250 pages and $0.45 for additional pages (K.S.A 65-4971(b)).

______________________________ ______________________________ ______________

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: ____

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.

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For Office Use Only: Records sent ______________________, 200__, By: ____________
(Date) (Initials)