Kansas City Bone & Joint Clinic, PA **Fax # (913) 901-0186**
10701 Nall Avenue, #200, Overland Park, KS 66211

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician, Dr. ____________________________ and/or administrative and clinical staff to (check all that apply):

___ use the following protected health information, and/or

___ disclose the following protected health information to:

(Complete Address)

[Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed for the following purposes:

[List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.]

This authorization shall be in force and effect until ____
[specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure] at which time this authorization to use or disclose this protected health information expires. ("End of the research study" and "none" is acceptable for authorization for research purposes.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 10701 Nall Ave., Suite 200, Overland Park KS 66211. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_______________________________________ ____
Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

____________________________________ ______________________ _________________________
Social Security Number Date of Birth AKA or other names used

____
Home Address & Phone Number

______________________ ____
Date Description of Personal Representative's Authority

NOTE: THERE IS A CHARGE FOR THESE RECORDS UNLESS MAILED DIRECTLY TO ANOTHER HEALTHCARE FACILITY FOR TREATMENT

[Provide a copy of this form to the patient.]