

College Park Family Care Center

AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

Patient Name:	Phone Number:
Date of Birth:	Address:

I authorize College Park Family Care Center to release medical information concerning the above named patient to:

Person(s) or Organization(s) authorized to receive the information

Address	City	State	Zip Code
Phone Number	Fax Number		

Specific description of the information that may be used or disclosed which includes date(s):

- Complete Medical Record-**Last two years unless otherwise specified.** (This will include information relating to substance abuse, mental health and HIV unless excluded by initialing below). _____
- Partial Medical Record (Specify what part(s) and the date(s)): _____
For example Lab reports, X-rays, Immunization record
- Other Specific Information: (Please specify and the date(s)): _____
- Referral to above from a College Park Family Care Center provider (No processing/copy fee charged)

I do not authorize the release of any information regarding: (Initial the corresponding line)

Substance Abuse _____ Mental Health Info. _____ HIV Info. _____

Specific description of how the information will be used:

I understand that this authorization will **expire** one year from the date of signature except as specified: _____.

- 1) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying College Park Family Care Center in writing.
- 2) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- 3) I may **inspect or copy** any information used or disclosed under this agreement. **A Request to Review/Release HealthCare Information Form must be completed.**
- 4) I understand that if the person or organization 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 would no longer be protected by these regulations
- 5) Patients requesting records to be transferred to another provider, third party (ex: Life Insurance, Law firm representing the patient, etc.) will be charged the following processing fee of \$18.97 with \$0.63 per page for the first 250 pages and \$0.45 per page for additional pages. If you request that copies of your health information be mailed to you, appropriate postage will be charged. If the third party refuses payment, the responsibility will revert back to the patient.
- 6) Our copy service, **DataFile Technologies**, will contact you regarding payment which must be received prior to the release of the records.

Printed Name of Patient or Patient's Representative

Relationship to Patient Date

Signature of Patient or Patient's Representative

Date

You can **fax** or **mail** the completed form to College Park Family Care Center **Attn: Centralized Medical Records**
Fax number: (913) 338-1311
Address: College Park Family Care Center Attn: Centralized Medical Records
 11755 W 112th St. Suite 201, Overland Park, KS 66210
Phone number: (913) 469-4106

NOTE: You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information."). You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)). You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).