AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION (42 CFR §164.508)

PATIENT NAME: _____ **D/O/B** _____ **SS#**_____

PARENTS NAME (IF INDIVIDUAL UNDER AGE OF 18): _____

PREVIOUS NAME/ALIAS (IF APPLICABLE): _____

Information Requested: I consent and authorize AcruxKC to disclose all Protected Health Information ("PHI") in any form (including oral, written or electronic) to AccessKC Partners/Vendors (list individual, facility, address, city, state, zip) (the "Requestor"). Additionally, I authorize AcruxKC to disclose the PHI via mail or facsimile. I expressly request that AcruxKC disclose full and complete PHI from the **time period of _____ to _____** including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers;
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;
- All radiology films; mammograms; myelograms; photographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos; and echocardiogram videos;
- All prescription and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;
- All correspondence to/from/about me, memos, office notes, narrative summaries, and telephone messages;
- All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;
- All documents related to the amendment of any record requested.

I request the information be disclosed in the following format _____. (If blank, format and method of disclosure will be determined by AcruxKC)

• I acknowledge that AcruxKC is receiving remuneration in the amount of _____ for this disclosure.

Purpose of Release	**AUTHORIZATION EFFECTIVE UNTIL:** □ 1 YEAR FROM DATE OF THIS AUTHORIZATION □ DATE
	□ OTHER EVENT OCCURS

I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Requestor at the address listed above. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand that the Requestor may redisclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.

Signature of Patient (if 18 years of age or older): _____ Date _____

Signature of Parent or Legal Representative (if applicable): _____ Date _____

Relationship to Patient, if not signed by Patient: _____

In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:

□ SUBSTANCE ABUSE (ALCOHOL/DRUG)
□ MENTAL HEALTH (INCLUDING PSYCHOLOGICAL TESTING)
□ HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)
□ GENETIC INFORMATION

THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF THIS CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROTECTED BY FEDERAL LAW, OR MENTAL HEALTH RECORDS PROTECTED BY STATE LAW, FURTHER DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE INDIVIDUAL OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUFFICIENT FOR THESE PURPOSES.

Signature of Patient (if 18 years of age or older): _____ Date _____

Signature of Parent or Legal Representative (if applicable): _____ Date _____

Relationship to Patient, if not signed by Patient: _____