

# AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-7 must be completed. If any block is not completed, then this "Authorization Form" will be considered incomplete and defective and cannot be used.

**PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.**

**Block 1: Identification of Patient**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
PATIENT'S ADDRESS: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_

**Block 2:** Type of Records/Information to be Disclosed: please describe what specific records/information may be used or disclosed. Psychotherapy notes may not be included; a separate authorization is required. (examples: all, x-rays only, records for the last 12 months...)

**Block 3:** Persons, facility, or class of persons who are authorized to use or disclose (provide) the records/information:

**Sunflower Ob-Gyn, PA**  
1230 E. 6<sup>th</sup> Suite 2D  
Winfield, KS 67156  
Phone 620.222.6250  
Fax 620.222.6251

**Block 4:** Persons, facility, or class of persons who are authorized to receive the records/information:

**Block 5:** Expiration: this "Authorization" will expire on \_\_\_\_\_, or on the following specific event:

**Block 6:** Purpose for which you wanted records/information used or disclosed:

**Block 7: Authorizing Signature**

- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations
- I may inspect or obtain a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation.
- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Personal Representative's Relationship to Patient

\_\_\_\_\_  
Printed Name of Personal Representative