

Lincoln Center OBGYN
800 SW Lincoln
Topeka, KS 66606
785.233.5101
785.233.1404, fax

Lincoln Center OBGYN
2830 SW Urish Rd
Topeka, KS 66614
785.273.4010
785.273.8530, fax

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient (PLEASE PRINT)

Social Security #

Date of Birth

Street Address

City, State, Zip

Maiden or other names used for records

DATE THIS AUTHORIZATION EXPIRES (If no expiration date indicated
Authorization will expire 1-year from the date of signature)

RELEASE FROM:

RELEASE TO:

Name (PLEASE PRINT)

Name (PLEASE PRINT)

Address

Address

City, State, Zip

City, State Zip

The following protected health information is to be disclosed: (please check all that apply)

- Complete health record
 Surgical notes
 Pregnancy records
 Other _____

Covering the period from _____ to _____

Unless specifically indicated, only up to the last three years of records will be copied

Purpose of Release: (please check all that apply)

- Transfer of care
 Moving
 Continuation of care
 Other _____

I understand that I have the right to revoke the authorization by delivering such revocation in writing to Lincoln Center OB-GYN except to the extent it has acted in reliance thereon. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by the federal privacy laws. Lincoln Center OB-GYN will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for disclosure of the protected health information to such third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure of the requested information will result in any remuneration to Lincoln Center OB-GYN from a third party, a statement about such remuneration will exist in this authorization.

I understand that records to be used or disclosed pursuant to this authorization may contain records and information relating to participation in any federally assisted drug and alcohol abuse programs, information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session, and information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to 45 C.F.R. 164.508; 42 C.F.R. Part 2; K.S.A. 65-5601 et seq; and K.S.A. 65-6001 et seq. By my signature, I authorize Lincoln Center OB-GYN to use or disclose records containing such information if they are otherwise included within the scope of this authorization. As to the records disclosed or used, I understand that these records shall not be re-disclosed without my express written permission. I understand that I may request a copy of this authorization.

Patient's Signature: _____ Date: _____

Signature of Personal Representative of Patient: _____ Date: _____

Description of Representative's Authority to Act for Patient: _____

Representative's Address and Phone Number: _____