NEW MEDICAL
HEALTHCARE

**2131 N Ridge Rd**
**Wichita, KS 67212**
**Fax:** (316) 440-6601
**Phone:** (316) 773-1212

# Authorization to Use or Disclose Protected Health Information

**I hereby authorize use and/or disclosure of the named individual's health information as described below:**

Patient Name: _____ DOB: _____

Address: _____ Phone: _____
*(Street, City, State, Zip Code)*

| **Receive Records From:** *(Name & Phone/Fax)* | **Release Records To:** *(Name & Phone/Fax)* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**** Only one (1) Facility per Request****

**To expedite your request, please be specific in your choice of records:**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Physician Notes | ☐ | ☐ | MRI/CT Scans |
| ☐ | ☐ | Lab Results | ☐ | ☐ | Cardiac Studies |
| ☐ | ☐ | X-Ray Reports | ☐ | ☐ | **Complete Records** |

**OTHER:** _____
_____

**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
**Redisclosure:** I understand that any disclosure of information carries the potential for redisclosure, and that the information then may not be protected by federal confidentiality rules.
**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand that the revocation will not apply to information already released based on this authorization.
**Other Rights:**

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
2. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

_____ **Date:** _____
**Signature of Patient/Legal Representative**

**Witness (Clinic Employee):** _____

**Permission to FAX records for medical emergency?** ☐ **YES** ☐ **NO**

**This authorization expires ninety (90) days from the date of this signature.**