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# MEDICAL RELEASE FORM

## Authorization To Use Or Disclose Protected Health Information

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

patient name	date of birth	Social Security Number
address (street, city, state, zip code)		telephone number

The following individual or organization is authorized to make the disclosure:

**(FROM) Dr.** \_\_\_\_\_ (first name) \_\_\_\_\_ (last name) \_\_\_\_\_  
 (address) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (phone) \_\_\_\_\_

This information may be disclosed to and used by the following individual or organization:

**(TO) Dr.** \_\_\_\_\_ (first name) \_\_\_\_\_ (last name) \_\_\_\_\_  
 (address) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (phone) \_\_\_\_\_

treatment dates: \_\_\_\_\_ purpose of request: \_\_\_\_\_

The following information is to be disclosed: (Please check one box for each item.)

- | Yes                      | No                       | Yes                      | No                       |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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 with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. I understand that I am authorizing the disclosure of all such records in the possession of PCA, including additional records that may come into its possession, whether it creates or compiles such records or receives records from another source.

**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:** (a) 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.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event or condition, this authorization will expire in six months.)

signature of patient or legal representative \_\_\_\_\_ date \_\_\_\_\_

if signed by legal representative, relationship to patient: