Primary Care Associates
7111 E. 21st St. North, Suite A
Wichita, KS 67206
Tel: 316-684-2851
Fax: 316-683-5239

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	
☐	☐	physician notes	☐	☐	lab results
☐	☐	x-ray reports	☐	☐	MRI scans
☐	☐	cardiac studies	☐	☐	complete record
☐	☐	other_____			

If changing physicians, please indicate reason for change: (Please check one box)

___Moving	___Office Staff	___Medical Care
___Insurance Change	___Receptionist	___Availability
___Office Location	___Medical Assistant	___Financial
___Appointment Scheduling	___Nurse	___Other _____
___Time Spent in Waiting Room	___Provider	

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.

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:

Primary Care Associates

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Medical Release Policy

It is the policy of Primary Care Associates to charge for requested copies of a consumer's medical records. A reasonable fee may include actual costs for copying, labor, mailing, shipping, or delivery.

Primary Care Associates may request that the fee be paid prior to release of the information for non-treatment or non-emergent purposes. Copies of records from other health care practitioners contained in Primary Care Associates records may also be made and given upon request. However, we cannot authenticate other providers' copies we have in our possession. A written release is required prior to releasing any records.

Primary Care Associates may charge the following:

1. Lawyers, court reporters
2. Insurance companies for reason other than payment purposes
3. Social Security Administration, SSI
4. Patients or their legally authorized representative for personal purposes such as copies to take to another provider, hospital, nursing home, home health agency or school, etc.
5. Records related to Workers Compensation cases according to the following fee schedule implemented by the State of Kansas Division of Workers Compensation effective December 1, 2001.

We will not charge a patient for their records when records are sent directly to another doctor, a VA office, a military facility or when the patient is leaving the country.

Charges for copies of records will be as follows:

Dictated Report $30 fee

Medical Records $18.97 fee

- No Charge for the pages between 1-10
- $.63 per page for the first 250 pages
- $.45 per page after first 250 pages