

DICKSON-DIVELEY
ORTHOPAEDICS

AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Office Use Only: Doctor _____ Chart # _____ Phone # _____
--

I, _____, date of birth _____, consent to and
(Print name)

authorize the Dickson-Diveley Orthopaedics to furnish to:

(Name of person or facility, address, city, state, zip.)

the following medical records and information: (please specify which body part)

(Specify patient name, admission date or period concerned)

for the following purpose: _____

I specifically authorize the release of types of information initialed below:

- ____ Alcohol and drug abuse treatment
- ____ HIV status or AIDS
- ____ Mental Health
- ____ Genetic Information

I understand I may revoke this authorization in writing at any time except already acted upon. To revoke this authorization I must send a request in writing to: Dickson-Diveley Orthopaedics Attn: Medical Records, at 3651 College Blvd. Leawood KS 66211.

This authorization expires on _____ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event.

I authorize the release of my records: (check one)

- ____ Only records originated prior to today's date (not including today's date).
- ____ Records originated both before and after today's date (including today's date).
- ____ Records originated only after today's date (including today's date).

I understand that my information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by the Privacy Regulations. A copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Authorized Representative Date

If Authorized Representative, Relationship to Patient: _____

Witness Date

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I prefer to receive my medical records by:

- Secure Message email _____ (email address)
- fax _____ (fax number)

Pick up at: Leawood location Plaza location mail to address listed above

Once completed, please FAX this form to: 913-253-1701