

REPRODUCTIVE RESOURCE CENTER OF GREATER KANSAS CITY, P.A.
AUTHORIZATION TO USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I, _____, date of birth _____, consent to and
(please print)

authorize:

Name: _____

Address: _____

City, State, Zip _____
(i.e. person or facility, address, city, state, zip)

to furnish to:

Reproductive Resource Center of Greater Kansas City, P.A.
12200 W. 106th, Suite 120
Overland Park, KS. 66215
Phone: 913-894-2323
Fax: 913-894-0841

the following medical records and information: _____
(i.e. all, dates of service, admission date, or period concerned)

for the following purposes: _____ (list all purposes).
(i.e. medical only, financial only, medical and financial)

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 this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization, I must send the written request to _____ at _____. 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 entire medical records containing all information provided to or developed by the Practice including information in the record associated with third parties relating to (check one):

- Treatment rendered prior to the date this authorization is signed
- Treatment rendered both before and after the date this authorization is signed
- Treatment rendered only after the date this authorization is signed

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

Date Signature of Patient

Signature if Personal Representative (ie.parent of minor child) _____

If Personal Representative, Relationship to Patient: _____ 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.