AUTHORIZATION TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO REPRODUCTIVE RESOURCE CENTER

I, ____, date of birth ______________, consent to and authorize:
(please print)

Name: ____

Address: ____

City, State, Zip ____

(i.e. person or facility, address, city, state, zip)

to furnish to:
Reproductive Resource Center
12200 W. 106th St.
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 _____ Mental Health
_____ HIV status or AIDS _____ 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.