

Authorization for Release of Healthcare Information

Patient Name: _____

Date of Birth: _____

I hereby authorize the transfer of the following healthcare information:

To: Family Medicine at Tallgrass From: _____
601 SW Corporate View, Ste. 200 _____
Topeka, KS 66615 _____
Phone: (785)234-2400 _____
Fax: (785) 271-2220 _____

Entire contents of chart

OR

- Progress notes Pathology reports Lab reports
 Correspondence Operative reports Psychotherapy notes

Purpose of Disclosure:

Continuing Patient Care Other _____

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this Authorization is subject to revocation. Withdrawal by me at any time in writing to the custodian of medical records in your office, except to the extent the action has already been taken to release this information to Family Medicine at Tallgrass. This authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, your office will not release my health information to Family Medicine at Tallgrass. Notice is given to Family Medicine at Tallgrass that law prohibits the re-disclosure of any health information regarding drug and / or alcohol abuse, HIV, and mental health treatment.

Signature of Patient Date

Signature of Parent or Guardian Date

Signature of Witness Date

Relationship to Patient Date