Wichita Surgical Specialists, P.A.
DBA Mid-Kansas Ear Nose and Throat
Protected Health Information Disclosure Authorization Form

Patient Name:_____ Birth Date:_____ Date of Request:_____

Contact Phone Number:_____

CHECK ONE:

_____ I hereby authorize WICHITA SURGICAL SPECIALISTS, P.A. (WSS) to disclose PROTECTED HEALTH INFORMATION concerning the above named person to:

_____ Fax Number:_____
Name(s) of person(s) or organization(s) to which disclosure is to be made.

_____
Address City State Zip

_____ I hereby authorize _____to disclose PROTECTED HEALTH INFORMATION concerning the above named person **to WICHITA SURGICAL SPECIALISTS, P.A., 10090 E Shannon Woods Cir Wichita, KS 67226 Fax: 316-684-3326**

For treatment date(s): _____

Reason for disclosure:_____

Type of Information to be released:
_____ Entire Record (will not include billing records or records not prepared by or on behalf of WSS unless items specifically requested.

_____ Other Specific Information:_____

This authorization shall remain in effect for 60 days from the request unless otherwise specified expiration date: _____

I understand that the records to be disclosed pursuant to this authorization may contain ____ records relating to participation in any federally assisted drug and alcohol abuse program; ____ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); ____ information relating to HIV testing, HIV status or AIDS. I understand such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $15 per request, a copying charge of up to $0.50 for the first 250 pages and $0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Wichita Surgical Specialists, P.A.'s Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Privacy Officer, Wichita Surgical Specialists, P.A. DBA Mid-Kansas Ear Nose and Throat, 10090 E Shannon Woods Cir, Wichita, KS, 67226.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Printed Name: _____
(Patient or Legal Guardian)