

Gashland Clinic
Authorization for Use and Disclosure of Patient Health Information

Patient Information:

Patient Name: _____ SSN# _____ D.O.B. _____

Address: _____ Phone _____

The following individual/facility is authorized to make the disclosure described in this form:

Gashland Clinic
 9411 N. Oak #100
 Kansas City, Mo 64155

OR

The information to be disclosed is:

- All information during the most recent two (2) years (except as noted below)
- All information during the most recent five (5) years (except as noted below)
- Specific information/specific time period:

Check below if you do **NOT** want any of the following information disclosed:

- relating to care and treatment for mental health conditions
- relating to care and treatment for drug and alcohol abuse
- relating to HIV testing, infection status, or care and treatment for HIV/AIDS]
- relating to genetic testing

The purpose of the disclosure is:

The information is to be disclosed to:

Name: _____
 Address: _____
 City _____ State _____ Zip: _____

- Please mail copies to the address indicated at left.
- I am planning to pick up the copies. Please call me when they have been copied.

Expiration: This authorization expires upon the following date or event: _____. If left blank, I agree that this authorization shall be valid for a period of six (6) months from today's date.

Revocation: I understand that I have the right to revoke this Authorization at any time, except to the extent that the Clinic has already taken action in reliance of this Authorization. I may revoke this Authorization by submitting my revocation in writing to the Provider at the address stated above.

Redisclosure: I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be subject to protection under the Provider's policies and procedures or federal laws protecting the privacy of patients' health information.

Voluntary: I understand that the Provider does not condition the patient's treatment on my execution of this Authorization and that I may refuse to sign this Authorization. However, if the Provider is providing health care treatment to the patient solely for the purpose of creating health information for disclosure to the person or entity named above, if I refuse to sign this authorization, the Provider may not provide such health care treatment to the patient.

 Signature of Patient/Parent/Guardian/Legal Representative

 Date