AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION (42 CFR §164.508)

ORTHOPAEDIC & SPORTS MEDICINE AT CYPRESS, LLC
9300 E. 29th St. N Suite 205 Wichita, KS 67226 * Phone: 316-219-8299 * Fax: 316-219-5899

PATIENT NAME: _____ **D/O/B** _____ SS# _____

PARENTS NAME (IF PATIENT UNDER AGE OF 18): _____

PREVIOUS NAME/ALIAS (IF APPLICABLE): _____

Information Requested: I consent and authorize Orthopaedic & Sports Medicine at Cypress, LLC to disclose all Protected Health Information in any form (including oral, written or electronic) to:
NAME or FACILITY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ (**list individual, facility, address, city, state, zip**) (the "Requestor"). Additionally, I authorize Orthopaedic & Sports Medicine at Cypress, LLC to disclose the Protected Health Information via mail or facsimile. I expressly request that Orthopaedic & Sports Medicine at Cypress, LLC disclose full and complete Protected Health Information from the **time period of _____ to _____** including, but not limited to, the following:

- ❑ All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers;
- ❑ All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;
- ❑ All radiology films; mammograms; myelograms; photographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos; and echocardiogram videos;
- ❑ All prescription and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;
- ❑ All correspondence to/from/about me, memos, office notes, narrative summaries, and telephone messages;
- ❑ All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;
- ❑ All documents related to the amendment of any record requested.

- ❑ I acknowledge that Orthopaedic & Sports Medicine at Cypress, LLC is receiving remuneration in the amount of $0.63 per page for this disclosure.

PURPOSE OF RELEASE:
- ❑ CONTINUATION OF CARE
- ❑ LEGAL/ATTORNEY
- ❑ PERSONAL USE
- ❑ OTHER

AUTHORIZATION EFFECTIVE UNTIL:
- ❑ 1 YEAR FROM DATE OF THIS AUTHORIZATION
- ❑ DATE _____
- ❑ OTHER EVENT OCCURS _____

IF NO DATE GIVEN AUTHORIZATION WILL EXPIRE ONE YEAR FROM EFFECTIVE DATE

I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Requestor at the address listed above. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand that the Requestor may redisclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.

Signature of Patient (if 18 years of age or older): _____ Date _____

Signature of Parent or Legal Representative (if applicable): _____ Date _____

Relationship to Patient, if not signed by Patient: _____

In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:

- ❑ SUBSTANCE ABUSE (ALCOHOL/DRUG)
- ❑ MENTAL HEALTH (INCLUDING PSYCHOLOGICAL TESTING)
- ❑ HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)
- ❑ GENETIC INFORMATION

THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF THIS CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROTECTED BY FEDERAL LAW, OR MENTAL HEALTH RECORDS PROTECTED BY STATE LAW, FURTHER DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PATIENT OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUFFICIENT FOR THESE PURPOSES.

Signature of Patient (if 18 years of age or older): _____ Date _____
Signature of Parent or Legal Representative (if applicable): _____ Date _____
Relationship to Patient, if not signed by Patient: _____