**Sedgwick County, Kansas**

# AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| CLIENT'S NAME: | BIRTH DATE: | ADDRESS: |
|---|---|---|
| | | |

## CHECK ONE:

☐ I HEREBY AUTHORIZE SEDGWICK COUNTY TO USE PROTECTED HEALTH INFORMATION ("PHI") CONCERNING THE ABOVE-NAMED PERSON OR TO DISCLOSE PHI TO THE FOLLOWING:

_____

*Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made.*

☐ I HEREBY AUTHORIZE _____ TO DISCLOSE PHI CONCERNING THE ABOVE-NAMED PERSON TO SEDGWICK COUNTY.

For treatment date(s): _____ to _____
*Starting Date* *Ending Date*

For the following purpose(s): _____

***If the request is initiated by the individual (or his/her representative), insert "at the request of individual"; otherwise, describe purpose of the use or disclosure. If the purpose relates to marketing, indicate whether Sedgwick County will receive remuneration.***

**CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED**

**Unless the appropriate box is checked, Sedgwick County will *not* disclose or use PHI prepared by health care providers not affiliated with Sedgwick County unless the PHI were prepared on behalf of Sedgwick County.**

| | | |
|---|---|---|
| ☐ Demographic Information | ☐ Physician Progress Notes | ☐ Entire Record (will not include billing records or records not prepared by or on behalf of Sedgwick County unless those items also are selected). |
| ☐ Payment Records | ☐ Physician Orders | |
| ☐ Lab Test Results | ☐ Discharge Summary | |
| ☐ Admission History & Physical | ☐ Nursing Notes | |
| ☐ Consultation Reports | ☐ Billing Records | ☐ Records not prepared by or on behalf of Sedgwick County. Sedgwick County cannot be responsible for the completeness or accuracy of such records. |
| ☐ Operative/Procedure Reports | ☐ Therapy Notes | |
| ☐ Imaging/Radiology Reports | ☐ Other _____ | |

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified PHI expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 360 days after the date listed below.

_____ 1) I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as stated above;

____ 2) I understand this may include 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);

____ 3) I understand this may include information relating to HIV testing, HIV status, or AIDS. I understand that 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 PHI as described. 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 is no longer protected by those regulations.*
*I understand Sedgwick County may charge fees to provide copies of records, and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act to this purpose. I understand that I may revoke this authorization at any time by providing a 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 Sedgwick County's "Notice" of Privacy Practices by mailing or hand-delivering written notification to the following person: Department Privacy Office. (Please see additional page for mailing and contact information.)*

_____ _____
*Date* *Signature of Individual/Individual Representative*

_____ _____
*Printed Name of Representative and Relationship* *Representative address and telephone number*

*Date* _____ _____ _____ _____
*Signature of Witnessing Sedgwick County Employee* *Department* *Phone*

_____
*Signature of Interpreter (If applicable)* ***Copy to Client's file***