



AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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.

I understand that the records to be used or disclosed pursuant to this authorizations may contain:
 _____ 1) Records relating to participation in any federally assisted drug and alcohol abuse program;
 _____ 2) 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) 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

Signature of Interpreter (If applicable)

Copy to client's file.