

Advanced Orthopaedic Associates, P.A.

East – 2778 N Webb Rd – Wichita, KS 67226
West – 10700 W St Teresa, Ste 165 – Wichita, KS 67235
(316) 631-1600/Fax (316) 631-1617

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN SPECIAL CIRCUMSTANCES

Name of Patient _____ Mailing Address _____
Social Security _____ Phone _____ DOB _____

Check One:

- I HEREBY AUTHORIZE ADVANCED ORTHOPAEDIC ASSOCIATES, P.A. (AOA) TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE NAMED PATIENT TO:

Name(s) of person (s) / organizations (s) or class(es) of persons/organizations with the complete mailing address

- I HEREBY AUTHORIZE _____
Name(s) of person (s) / organizations (s) or class(es) of persons/organizations with phone number
TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE NAMED PATIENT TO AOA.

Treatment Dates Covered by this Authorization: _____

The Purposes Requiring Use, Receipt or Disclosure: _____
If the request is initiated by the patient (or the patient's representative), insert "at the request of patient"; otherwise, describe the purpose.

Type of Information Authorized to be Used and/or Disclosed. Check All Boxes that Apply:

If this authorization applies to the complete office medical records, check here . Otherwise, specify your request by checking appropriate boxes in the three columns below.

Specify Data Requested

- Office Notes
- Surgery Reports
- Therapy Reports
- Billing Records
- X-ray Films
- X-ray Reports

Specify Treating Physician

- Dr. Dart
- Dr. Fanning
- Dr. Gwyn
- Dr. Hearon
- Dr. Jansson
- Dr. Klaumann
- Dr. Lucas
- Dr. Morris
- Dr. Murtha
- Dr. Pappademos
- Dr. Pollock
- Dr. Prohaska
- Dr. Schurman
- Dr. Shields

Specify Encounter/Problem

- Shoulder
- Elbow/Arm
- Wrist/Hand
- Back/Spine
- Hip/Leg
- Knee
- Ankle/Foot

Effective Date:

This authorization shall remain in effect until _____ (date) or _____ (specific occurrence or event) at which time the authorization shall expire. Date or occurrence must be no later than one year from the date of authorization. If this item is left blank, this authorization shall remain effective for 60 days.

Protected Health Information Concerning Alcohol or Drug Treatment or HIV Status:

I understand that the records to be used or disclosed pursuant to this authorization may contain _____ (initials) records relating to participation in a federal assisted drug or alcohol abuse program; _____ (initials) information relating to the diagnosis and treatment of alcohol or drug dependency or a mental or emotional condition (other than notes recorded by a mental health professional documenting or analyzing a counseling session); _____ (initials) information relating to 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 above, I authorize use or disclosure of records containing such information.

Authorization:

I the undersigned authorize the disclosure of the health information described above. I understand that treatment is not conditioned upon the signing of this authorization. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed and may no longer be 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 \$18.40 per request plus \$.60 per page up to 250 pages, then \$.44 for each additional page. There will be a charge of \$10 for all radiology CD's. Pre-payment of these charges may be required. I understand that I may revoke this authorization at any time by providing a written notice to AOA (see reverse) except to the extent that action has been taken in reliance upon this authorization or except as otherwise stated in AOA's Notice of Privacy Practices.

Signature of Patient or Patient Representative

Date

Patient or Representative Mailing Address and Telephone Number

Printed Name of Patient or Representative and Relationship to Patient

Signature of Witness

Date

Original to be maintained in patient's permanent medical record.

Revocation of Authorization:

I, _____(name), HEREBY REVOKE THE AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION DESCRIBED ON THE REVERSE OF THIS PAGE.

Signature of Patient or Patient Representative

Date

Patient or Representative Mailing Address and Telephone Number

Printed Name of Patient or Representative and Relationship to Patient

Signature of Witness

Date