AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM MCCLURE MEDICAL PRACTICE

FAX TO 877-795-5238

RECORDS MAY UP TO TAKE 2 WEEKS TO BE SENT

Instructions: All of the Blocks 1-5 must be completed. If any block is not completed, then this "Authorization Form" will be considered incomplete and defective and cannot be used.

Block 1: Identification of Patient

PATIENT NAME_____ BIRTHDATE_____SSN_____

PATIENT'S ADDRESS_____

Block 2: Type of Records/Information to be disclosed:

☐ Medical Records will be faxed free of charge

☐ CDs of Ultrasounds will be mailed at a cost of $10

Call 620-218-1623 to pay over the phone or mail a check to the office address, below.

Block 3: Persons, Facility, or class of persons who are authorized to use or disclose (provide) the records/information:

McClure Medical Practice
901 Main St, Suite 101
Winfield, KS 67156
Phone: 620-218-1623
Fax: 620-402-5044

Block 4: Persons, facility or class of persons who are authorized to receive the records/information:

Facility:

Address:

Phone:

Fax:

Block 5: Authorizing Signature:

- I understand that if the person or entity that receives the described records/information is not a Health Care Provider or Health Plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I may inspect or obtain a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation.
- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____

Signature of Patient or Patient's Personal Representative Date of Signature

_____ _____

Personal Representative's Relationship to Patient Printed Name of Personal Representative