Midwest Medical Specialists
Authorization for Use and Disclosure of Patient Health Information

Printed Patient Name:_____
Date of Birth:_____
Social Security Number:_____

- **I authorize Midwest Medical Specialists, P.A.**, "MMS", to use and/or disclose the following health information from my medical record:

  _____
  (Describe information, including dates of service, types of conditions or all records)

- I specifically authorize MMS to disclose the types of information selected below:
  _____ Information relating to care and treatment for mental health conditions
  _____ Information relating to care and treatment for drug and alcohol abuse
  _____ Information relating to HIV testing, infection status, or care and treatment for HIV/AIDS
  _____ Information relating to genetic testing

- The above information may be **disclosed to:**

  _____
  (Name of person/facility and complete address)

- The disclosure is for the purpose of:_____
  If no purpose is stated, the disclosure is made at my request.

- This Authorization expires on the following date or event: _____
  If left blank, this Authorization will expire one (1) year from the date this Authorization is signed.

- I understand that I have the right to revoke this Authorization at any time, except to the extent that MMS has already taken action in reliance on this Authorization. I may revoke this Authorization by submitting my revocation in writing to MMS at the address stated above.

- I understand that the information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be subject to protection under MMS's policies and procedures or federal laws protecting the privacy of patients' health information.

- I understand that MMS does not condition my treatment on my signing this Authorization and that I may refuse to sign this Authorization. However, if MMS is providing health care solely to create information for disclosure to the third-party named above, MMS will not provide health care unless I sign this Authorization.

_____
Patient's Signature

_____
Date

If someone other than the Patient signs this Authorization:
Printed Name:_____
Relationship to Patient:_____
____Legal Guardian _____Parent
Other:_____(please specify)

Please return to: Midwest Medical Specialists, P.A., Attn: Medical Records Department
5330 North Oak Trafficway, Suite 201 Kansas City, MO 64118 Phone 816.454.0666 Fax 816.454.1694