Authorization for Obtaining and Disclosing of Patient Health Information

Printed Patient Name: _____

Date of Birth: _____

Requesting Provider: _____

Provider we are requesting from: _____

(Name of provider/facility with complete address and phone number)

- **I authorize Midwest Medical Specialists, P.A.," MMS**", to obtain 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/or alcohol abuse
  _____ Information relating to HIV testing, infection status, or care for HIV/AIDS
  _____ Information relating to genetic testing
- 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 the authorization will expire one (1) year from the date signed.)
- I understand that I have the right to revoke this authorization at any time, except to the extent that MMS has already acted in reliance of this authorization. I may revoke this authorization by submitting my revocation in writing to MMS at the states address.
- I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be subject to protection under MMS'S policies and procedures or federal laws protecting the privacy of patient's 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 healthcare solely to create information for disclosure to the third-party named above, MMS will not provide healthcare 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 (Specify)

Please return to Midwest Medical Specialists, P.A., Attn: Medical Records Department

5330 N. Oak Trafficway, Suite 201 Kansas City, MO 64118 Phone 816.454.0666 Fax 816.559.7118