

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

FAX TO 620-402-5044

RECORDS MAY UP TO TAKE ONE WEEK 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