ASHLEY CLINIC, LLC – CHANUTE

P.O. Box 946 Chanute, KS 66720
Phone (620)431-2500 Fax (620)431-0914

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____ **Account #:** _____

Patient Address: _____ **Daytime Phone:** _____

I hereby authorize _____ to disclose protected health information to:
Name: _____
Address: _____ **Daytime Phone:** _____
for the following purpose(s):

- ☐ At the request of the patient/representative
- ☐ Other: _____

Format for production of health information (electronic format, paper copies, email)_____

Note: Protected health information provided on portable electronic media will not be encrypted and may be at risk for inadvertent disclosure if you lose the media or it is stolen. E-mail communication can be intercepted in transmission or misdirected. By requesting the use of portable electronic media or by providing your e-mail address above you accept these risks.

Type of information to be released: (Check only applicable records to release)

- ☐ Billing Records
- ☐ Progress/Office Visit Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports (x-rays, sonograms, images, etc.)
- ☐ Cardiac Studies (EKGs, Holter Monitors, etc.)
- ☐ Physical Exams (work, school, sports, KAN Be Healthy, etc.)
- ☐ Procedure Reports (lesion removal, joint injections, etc.)
- ☐ Correspondence (Letters, etc.)
- ☐ Immunizations
- ☐ Ancillary Studies (spirometry, audiometry, etc.)
- ☐ Psychotherapy Notes
- ☐ HIV/AIDS Test Results
- ☐ Records related to participation in any federally assisted drug and alcohol abuse program
- ☐ Entire Record (will not include billing records or records not prepared by or on behalf of this facility unless those items also are selected)
- ☐ Records not prepared by or on behalf of this facility. This facility cannot be responsible for the completeness or accuracy of such records.
- ☐ Other _____

Dates of Service For Record Release: From: _____ To: _____

This authorization shall remain in effect until _____(date) or _____(occurrence of specified event) at which time this authorization to disclose the identified health information expires. If no date is provided this authorization will expire one year from the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain:
1) records relating to participation in federally assisted drug and alcohol abuse programs _____ **(Initials)**
2) information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than those notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes) _____**(Initials)**
3) information relating to HIV testing, HIV status, or AIDS _____**(Initials)**
I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my signature/initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by giving written notification to the Privacy Officer at Ashley Clinic, LLC.

Signature of Patient: _____ or Patient Representative _____ Date: _____
Patient/Representative (print): _____ Relationship: _____
Witness: _____ Title: _____

Verification of Information Released

Sent by Mail on (date)_____ Certified? (certification #:_____
Faxed to: (number)_____ on (date) _____
Picked up by: (name) _____ on (date) _____
Verification of identification by: _____ or ☐ drivers license ☐ picture ID ☐ other _____
Sender's Initials: _____ Check #: _____

AshleyClinic		Medical Record #: _____ Account #: _____

Ashley Clinic

Instructions for completing the Authorization for the Release of Confidential Information

- Complete the first section with patient name, date of birth, address and daytime telephone number.
- **I** hereby authorize *company* to disclose health information: Complete the name of the company that has your health information; **ie; Ashley Clinic**. If the copies are for you, state "Self" in the name field, if **not** state name and full address and phone number of the company/individual to receive the information.
- **I request the following PHI to be released from my medical record(s):** Mark the documents that you are requesting. An abstract or pertinent documentation includes key physician notes and test results. This is what most other health care providers like to have. When selecting either pertinent documentation or complete record, please note that we will send only the last two years unless otherwise specified. Test results when marked individually are generally for specific dates of service as indicated in the next section.
    - *Billing records are NOT kept in the Health Information Management Department. If you are requesting billing records only, mail this form to Ashley Clinic Business Office at PO Box 946, Chanute, KS 66720. You may call the business office at 620-431-2500, ext. 214.*
- **Format to receive information:** Please indicate how you would like to receive the information: electronic format, paper copies or email. If email is the preferred method of receiving the information, please enter email address.
- **Specific treatment dates:** Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.
- **Authorization timeframe:** Please indicate whether the disclosure of information has an expiration date. If no date is provided this authorization will expire one year from the release date.
- **Special protections pursuant to state and federal laws and regulations:** Please read and place your initials in the three (3) areas as indicated.
- **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate etc.) sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by an authorized representative.
- **Witness Signature:** A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please email or call Health Information Management at 620-431-2500 if you have any further questions.

Ashley Clinic – Health Information Management
505 S Plummer, Chanute, KS 66720
Attach Signed Form to E-Mail: medicalrecords@ashleyclinic.com or Fax: 620-431-0914

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