Great Plains Diabetes
Authorization for the Release of Protected Health Information

834 N Socora, Suite 4 **Phone: 316-440-2802**
Wichita KS 67212 **Fax: 316-440-2809**

Patient: _____ Birth Date: _____ Phone #: _____

Address: _____City:_____St:___ Zip: _____

☐ I hereby authorize Great Plains Diabetes to disclose protected health information concerning the above-named person

to:_____
Name of person/organization to release information to

_____
Fax Number *Phone Number* *Address* ***(Must have a fax number, phone number or address)***

☐ I hereby authorize _____
Name of person/organization to release information from

_____
Fax Number *Phone Number* *Address* ***(Must have a fax number, phone number or address)***

To disclose protected health information to **Great Plains Diabetes** concerning the above-named person

Check the specific type of information to be used or disclosed:

☐ Pertinent Health Information (1 years visit notes and labs) ☐ Lab Test Reports

☐ Complete Health Record (will not include billing records or records Not prepared by Great Plains Diabetes) ☐ Medication Records

☐ Billing Records ☐ Other:_____

Purpose of Request: ☐ Transfer of Care ☐ Other (must specify): _____

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by 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); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. 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 healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request, a copying charge of up to $0.63 for the first 250 pages and $0.45 for additional pages, salt mine retrieval fee of $50.00 and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated Great Plains Diabetes Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Belinda Childs, Great Plains Diabetes 834 N Socora Suite 4 Wichita KS 67212

_____ _____
Date *Signature of Individual / Patient Representative*

_____
Printed name of Representative and Relationship *Representative address and telephone number*