



Galichia Medical Group, P.A.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	BIRTH DATE	SOCIAL SECURITY No.
--------------	------------	---------------------

CHECK ONE:

I hereby authorize _____ to use or disclose protected health information concerning the above-named patient to **Galichia Medical Group, P.A.:**

Name(s) of person(s) or class(es) of persons/organizations to which disclosure is to be made (include: address, city, state, zip)

	Wichita	Fredonia	Independence
Please circle the clinic location to which you would like your medical records sent.	2600 N Woodlawn Wichita, KS 67220 316-684-3838	PO Box 556 Fredonia, KS 66736 620-378-3347	800 W Chestnut Independence, KS 67301 620-331-3333

For treatment date(s): _____
Specify date(s) – this line MUST BE completed

For the following purpose(s): _____
Describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Galichia Medical Group, P.A. will received remuneration.

Check Type of Information Authorized To Be Used and/or Disclosed

(Unless the appropriate box is checked, Galichia Medical Group, P.A. (GMED) will *not* disclose records contained in its medical records prepared by healthcare providers not affiliated with GMED unless the records were prepared on behalf of Provider)

- | | | |
|---|--|--|
| <input type="checkbox"/> Entire Record (will not include billing records or records not prepared by or on behalf of Galichia Medical Group, PA unless those items are also selected) | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Imaging/Radiology Reports |
| <input type="checkbox"/> Records not prepared by or on behalf of Galichia Medical Group, PA. Galichia Medical Group, PA cannot be responsible for the completeness or accuracy of such records. | <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Nuclear Medicine Reports |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Sonographic Reports |
| | <input type="checkbox"/> Problem Lists | <input type="checkbox"/> Treadmill / ECG Reports |
| | <input type="checkbox"/> Medication Records & Logs | <input type="checkbox"/> Preventative Rehabilitation Reports |
| | <input type="checkbox"/> Telephone Notes | <input type="checkbox"/> Pulmonary Function Reports |
| | <input type="checkbox"/> Office Correspondence | <input type="checkbox"/> Sonographic Records |
| | <input type="checkbox"/> Lab Test Reports | <input type="checkbox"/> Pacemaker Records |

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 this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

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; _____ information relating to HIV testing, HIV status, or AIDS; _____ psychotherapy notes. I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S.A. § 65-6001 et seq.

By my initials, I authorize Galichia Medical Group to use or disclose 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 use and/or disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization unless the purpose for this authorization is:

- for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, GMED reserves the right to deny treatment associated with such research
- to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, GMED reserves the right to deny that healthcare.

I understand that if the person or entity that receives the information is not a health care entity 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 as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the department identified below except to the extent that action has been taken in reliance upon it by mailing or hand-delivering written notification to the following person: Privacy Officer, 2600 N. Woodlawn, Wichita, KS 67220

_____	_____
<i>Date</i>	<i>Signature of Patient/Patient Representative</i>
_____	_____
<i>Printed Name of Patient Representative</i>	<i>Description of Personal Representative's Authority</i>
_____	_____
<i>Date</i>	<i>Signature of Witness</i>

ORIGINAL – Patient Medical Record

COPY – Patient