MID-AMERICA HEART AND VASCULAR CLINICS, LLC
200 Research Drive
Manhattan, KS 66503
Phone (785) 539- 4644
Fax (785) 539- 8010

AUTHORIZATION TO USE OR DISCLOSURE HEALTH INFORMATION

1. Patient Identification.

Name – Last, First, MI			
Street Address	City	State	Zip Code
Birthdate	Phone Number		

2. Information to be disclosed *(Please check all applicable categories).*

- ☐ Progress Notes
- ☐ Procedure Reports
- ☐ Entire Record
- ☐ Diagnostic Test Reports (lab, radiology, etc.)
- ☐ Records for Date of Service
- ☐ Other (describe):_____

3. Used/Disclosed By:

Name (e.g. Health Facility, Physician, Researcher)
Address
City State Zip Code

4. Disclosed To:

Name (e.g. Health Facility, Physician, Attorney, Patient)
Address
City State Zip Code

4. Purpose or need for disclosure. *(Please check all applicable categories.)*

- ☐ Further Medical Care
- ☐ Vocational Rehabilitation
- ☐ Legal Purposes
- ☐ Payment of Insurance Claim
- ☐ Application for Insurance
- ☐ Patient Use
- ☐ Vocational Rehabilitation
- ☐ Disability Determination
- ☐ Other (describe):_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present to my written revocation to the Mid-America Heart and Vascular Clinics, LLC Staff. I understand that the revocation will not apply to information that has already been released in response to do this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to it contest a claim under my policy. Unless I specify differently, this authorization will expire within *6 months* from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I authorize the above organization to disclose the above named individual's health information as described above.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____

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Signature of witness Date

Revised: 08/29/2018