

Patient's Full Name (Print): _____	
Former Name(s) (where applicable): _____	
SSN: _____	Date of Birth: _____
Phone: _____	Fax: _____

I, or my personal representative, hereby authorize Signature Medical Group of KC, P.A. (Signature or SMG) to use or disclose protected health information (PHI) regarding my care and treatment. I understand that:

- PHI relating to **ALCOHOL/DRUG ABUSE, MENTAL HEALTH, GENETIC TESTING, HIV/AIDS** and/or communicable diseases may be included in records and I authorize disclosure of such PHI. As applicable, I specifically authorize release of records related to certain treatment or conditions by placing my initials in the appropriate space(s) in Item 8(b).
- Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV/AIDS information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV/AIDS information without authorization.
- I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed in Item 5 below, except to the extent Signature has already relied upon this authorization.
- Signing this authorization is voluntary. SMG may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information (one Provider per form): Name: _____
 Address: _____ Phone: _____ Fax: _____

6. Purpose for requesting information: At my request Continuity of Care Other: _____

7. Person(s) to receive this information: Send to Name : _____
 Address: _____ Phone: _____ Fax: _____
 I will pick it up My personal representative _____ will pick it up (identification required for pick-up)
Note: Requests are subject to payment of copying/mailing fees and requests may be processed by an SMG business associate

8. Description of information being released: (a) Date(s) of service (required; list all dates): _____
I would like (choose one): An abstract (pertinent information related to the above listed date(s)) My entire Medical Record
 X-ray/MRI/Other Radiology (specify) _____
 other (specify) _____
(b) Release information relating to (*initial* beside each applicable category): Alcohol/Drug Treatment _____
 Mental Health Treatment _____ Genetic Testing Information _____
 Psychotherapy Notes (complete a separate authorization form for these notes) _____ HIV/AIDS _____

9. Date or event on which this authorization will end: One-Time Request Specific Event or End
 Date: _____ (Note: Unless otherwise revoked, if no end date/event is specified, this authorization will expire one year from the date signed for Kansas providers)

10. Signature: By signing below I acknowledge that I have read and agree with all of the above.
 Signature: _____ Date: ____/____/_____
 Print name of personal representative if signing for patient and specify authority: _____
 (supporting documentation required): Parent Guardian Health Care Agent Administrator/Executor Other _____
Note: When an authorization is sought by SMG, a signed copy of this form must be given to Patient or Personal Representative after signing