Wichita Surgical Specialists, P.A. Protected Health Information DISCLOSURE AUTHORIZATION FORM

| Patient Name | Birth Date | Address | |
|--|--|--|---|
| CHECK ONE: I HEREBY AUTHORIZE WICHITA SURGICAL SPECIALIST ABOVE-NAMED PERSON. I HEREBY AUTHORIZE WICHITA SURGICAL SPECIALIST | | | |
| THE ABOVE-NAMED TO: | | | |
| Name(s) of person(s) organization(s) or class(es) of persons/organ | | | |
| THE ABOVE-NAMED PERSON TO WICHITA SURGICAL | | ISCLOSE F | PROTECTED HEALTH INFORMATION CONCERNING |
| For treatment date(s): | ŕ | | |
| For the following purpose(s): | | | |
| If the request is initiated by the individual (or his/her repre | | | |
| disclosure. If the purpose relates to marketing, indicate whether Wichita Surgical Specialists, P.A. will receive remuneration. | | | |
| CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED Unless the appropriate box is checked, WSS will <i>not</i> disclose records contained in its medical records prepared by health care providers not affiliated with WSS unless the records were prepared on behalf of WSS. | | | |
| | Progress Notes | | Entire record (will not include |
| Payment Records Physician | _ | | Billing Records or records not |
| | Summary | | prepared by or on behalf of |
| Admission History & Physical Nursing N | | | WSS unless those items also |
| Consultation Reports Billing Rec | ords | _ | are selected). |
| ☐ Operative/Procedure Reports ☐ Imaging/Radiology Reports ☐ Other | | | Records not prepared by or on behalf of WSS. WSS cannot be responsible for |
| Illiagilig/Radiology Reports Other | | - | the completeness or accuracy of such records. |
| | | | the completeness of accuracy of such records. |
| | | | , |
| This authorization shall remain in effect until | | | (occurrence |
| of specified event) at which time this authorization to disc | close the identified hea | | nation expires, but no later than one year from |
| | close the identified hea | | nation expires, but no later than one year from |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs | close the identified hea zation shall remain eff uant to this authorizat | ective for | nation expires, but no later than one year from 60 days after the date listed below. |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol abo | close the identified heat zation shall remain effuant to this authorizat use program; inf | ion may o | nation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other | close the identified hear zation shall remain effunction until to this authorizatuse program; information than notes recorded | ion may of ormation or mation | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no | close the identified heat zation shall remain efformant to this authorizat use program; information of than notes recorded of the sare maintained seconds. | ion may of ormation by a mentoparately (| records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol abo alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV te | close the identified heat zation shall remain effort uant to this authorizat use program; infort than notes recorded otes are maintained se esting, HIV status, or A | ective for ion may o ormation by a men parately (DS. I und | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws and | close the identified heat zation shall remain efficient uant to this authorizations program; information in the program | ective for ion may o ormation by a meni parately (DS. I und initials, I | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol ab alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws a containing such information if they are otherwise included | close the identified hear zation shall remain efficient uant to this authorizate use program; information in than notes recorded better are maintained sees ting, HIV status, or All and regulations. By my dividing the scope of the state of the state of the scope of the state of the st | ion may of ormation by a meni parately (DS. I und initials, I | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authorization to disc I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included I, the undersigned, have read the above and authorize the | close the identified hear zation shall remain effortunant to this authorizations program; information in the notes are maintained seesting, HIV status, or All and regulations. By myd within the scope of the disclosure of such hear | ion may of cormation may a meniparately (DS. Tuncinitials, Inis autho | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such not psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws an containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this and | close the identified hear zation shall remain efficient unant to this authorizate use program; information in the notes recorded between the same maintained sees the same maintained sees the same maintained. By my disclosure of such hear thorization. I understation is a station of the same and the same are the same and the same are th | ion may of ormation may of a mention py a mention postale of the control of the c | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws as containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this as information is not a health care provider or health plan co | close the identified heat zation shall remain efficient unant to this authorizate use program; information in the notes are maintained seesting, HIV status, or Almod regulations. By myd within the scope of the disclosure of such heat wered by federal privation. I understivered by federal privation. | ion may of ormation may of a mention parately (DS. I und initials, I his authoralth informand that by regulation | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this at information is not a health care provider or health plan co- re-disclosed and no longer protected by those regulations | close the identified hear zation shall remain efficient under the this authorizate use program; information in the notes recorded between the same maintained sees the strong, HIV status, or And regulations. By myd within the scope of the disclosure of such hear the strong wered by federal private. I understand that fee | ion may of cormation may of a mention parately (DS. I undinitials, I nis autho alth informand that by regulates may be | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol ab alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws as containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this as information is not a health care provider or health plan co re-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to | close the identified hear zation shall remain efficient uant to this authorizate use program; information in than notes recorded between the same maintained sees the string, HIV status, or All and regulations. By my divident the scope of the disclosure of such hear the string wered by federal private and that fees \$15 per request, a coperation in the string private string in the st | ion may of cormation may of a mention parately (DS. I undinitials, I mis autho alth informand that by regulates may be bying chair | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of ree of up to \$0.50 for the first 250 pages and |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this at information is not a health care provider or health plan co- re-disclosed and no longer protected by those regulations | close the identified hear zation shall remain efficient unant to this authorizate use program; information in than notes recorded between the same maintained sees the sting, HIV status, or All and regulations. By my disclosure of such hear the state of the suthorization. I understate of the suthorization. I understate of the state of the suthorization. I understate of the state of the | ion may of cormation by a mention parately (DS. I undinitials, I mis autho alth informand that by regulates may be bying chart can that can that can be that can be seen as the can b | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of rige of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol ab alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws a containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this ac information is not a health care provider or health plan co re-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to \$0.35 for additional pages, and the reasonable cost of all of | close the identified hear zation shall remain efficient to this authorizate use program; information in the notes recorded between the same maintained sees the same maintained sees the same maintained sees are maintained sees are maintained sees the same maintained sees the same maintained sees the same maintaines. By my distributions. By my distribution in the scope of the same same same same same same same sam | ion may of cormation on a mening parately (DS. I undinitials, I mis autho alth informand that cay regulates may be onlying chait cannot by pro | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of rege of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard viding a written notice to the person identified |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authorization that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such not psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this at information is not a health care provider or health plan corre-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to \$0.35 for additional pages, and the reasonable cost of all ophotocopy machine. I understand that I may revoke this abelow except to the extent that action has been taken in reasonable cost of Privacy Practices by mailing or hand-delive | close the identified hear zation shall remain efficient unant to this authorizate use program; information in than notes recorded between the same maintained sees the string, HIV status, or And regulations. By myd within the scope of the disclosure of such hear the string wered by federal private. I understand that fee \$15 per request, a conduplications of records authorization at any time eliance upon it or excerning written notifications. | ion may of cormation may of cormation pay a mentiparately (DS. I undinitials, I nis authoral that can be by ing charted that can be by properties of the formation of the formation of the formation of the formation in the formation in the formation may be some pay as other to the formation may be some pay as other that can be some pay as other than to the formation may be some pay as other than to the formation may be some pay as other than to the formation may be some pay as other than the formation may be some pay as of the formation may be some pay as of the formation may be some pay a | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of age of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard widing a written notice to the person identified erwise stated in Wichita Surgical Specialists, following person: |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such no psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws as containing such information if they are otherwise included. I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this as information is not a health care provider or health plan co re-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to \$0.35 for additional pages, and the reasonable cost of all of photocopy machine. I understand that I may revoke this as below except to the extent that action has been taken in re- | close the identified hear zation shall remain efficient unant to this authorizate use program; information in than notes recorded between the same maintained sees the string, HIV status, or And regulations. By myd within the scope of the disclosure of such hear the string wered by federal private. I understand that fee \$15 per request, a conduplications of records authorization at any time eliance upon it or excerning written notifications. | ion may of cormation may of cormation pay a mentiparately (DS. I undinitials, I nis authoral that can be by ing charted that can be by properties of the formation of the formation of the formation of the formation in the formation in the formation may be some pay as other to the formation may be some pay as other that can be some pay as other than to the formation may be some pay as other than to the formation may be some pay as other than to the formation may be some pay as other than the formation may be some pay as of the formation may be some pay as of the formation may be some pay a | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of age of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard widing a written notice to the person identified erwise stated in Wichita Surgical Specialists, following person: |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such not psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included. I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this at information is not a health care provider or health plan corre-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to \$0.35 for additional pages, and the reasonable cost of all ophotocopy machine. I understand that I may revoke this abelow except to the extent that action has been taken in replaced to the extent that action has been taken in replaced to the privacy Practices by mailing or hand-delive privacy Offer, Wichita Surgical Special | close the identified hear zation shall remain efficient unant to this authorizate use program; information in than notes recorded between the same maintained sees the string, HIV status, or And regulations. By myd within the scope of the disclosure of such hear the string wered by federal private. I understand that fee \$15 per request, a conduplications of records authorization at any time eliance upon it or excerning written notifications. | ion may of cormation may of cormation may of cormation parately (DS. I undinitials, I mis authoral that can be by properties of the following characters of the following | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the cions, the information described above may be charged for preparing and sending copies of age of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard widing a written notice to the person identified erwise stated in Wichita Surgical Specialists, following person: |
| of specified event) at which time this authorization to disc the date listed below. If this item is left blank, the authori I understand that the records to be used or disclosed purs participation in any federally assisted drug and alcohol about alcoholic, drug dependency, or emotional condition, other conversation during a counseling session provided such not psychotherapy notes: information relating to HIV to specialist protections pursuant to state and federal laws at containing such information if they are otherwise included. I, the undersigned, have read the above and authorize the treatment is not conditioned upon the execution of this at information is not a health care provider or health plan con re-disclosed and no longer protected by those regulations records, including a charge for labor and supplies of up to \$0.35 for additional pages, and the reasonable cost of all of photocopy machine. I understand that I may revoke this a below except to the extent that action has been taken in representation. P.A.'s Notice of Privacy Practices by mailing or hand-delive Privacy Offer, Wichita Surgical Special | close the identified hear zation shall remain efficient under the transfer than notes recorded by the same maintained sees that the disclosure of such hear thorization. I understowered by federal private the disclosure of such hear thorization. I understowered by federal private \$15 per request, a conduplications of records authorization at any time eliance upon it or excepting written notification cialists, P.A., 551 N. Hill | ion may of cormation may of cormation may of cormation parately (DS. I undinitials, I nis authoral that can tha | mation expires, but no later than one year from 60 days after the date listed below. contain records relating to the relating to diagnosis and treatment of mental, tal health professional documenting or analyzing (unless this authorization pertains specifically to derstand that such information is subject to authorize the use or disclosure of records rization. mation as described herein. I understand that if the person or entity that receives the clons, the information described above may be charged for preparing and sending copies of rige of up to \$0.50 for the first 250 pages and not be routinely duplicated on a standard viding a written notice to the person identified erwise stated in Wichita Surgical Specialists, following person: the 201, Wichita, KS 67214. |