



Your Wellness Connection
 7410 Switzer
 Shawnee Mission, KS 66203
 Phone (913) 962-7408 Fax (913) 962-7416

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number (Day): _____ Phone number (Evening): _____

Address (Street or P.O. Box): _____

City: _____ State: _____ Zip: _____

I hereby authorize _____ to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of: _____

Date Range: _____

Released to: _____

Address: _____

Phone Number: _____ Fax Number: _____

For the specific purpose of: _____

I understand I have the right to revoke this Authorization provided that I do so in writing, except to the extent that YWC has already used or disclosed the information in reliance on this Authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient

Date

Signature of Person Authorized by Law

Relationship to Patient

Expiration Date: _____ Unless revoked earlier or otherwise indicated above, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Your Wellness Connection's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Authorization. Please verify that you have been notified of our Notice by placing your initials here: _____

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the lower left-hand corner. We will make available to you a copy of the current Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

