Authorization for Release of Protected Health Information (PHI)
Pratt Family Practice, PO Box 308, Pratt, Kansas 67124
Phone 620-672-7422 or Fax 855-884-8184

Please print all information

Patient's Name:_____ **DOB:**_____

I hereby authorize records obtained FROM:

Name: **Pratt Family Practice**
Address: **203 Watson, Suite 200**
City/State/Zip: **Pratt, KS 67124**
Phone: **620-672-7422**
Fax: **855-884-8184**

To be released TO:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Purpose of Disclosure:

- ☐ **Transfer of Care**
- ☐ **Consultation**
- ☐ **Other (Specify)**_____

Documents Requested:		**Time Frame Requested:**
	Immunization Record	Most Recent
	Lab/Pathology Reports	Last 2 Years
	Office Visits	Last 2 Years
	Operative Reports	Last 2 Years
	X-ray Reports	Last 2 Years
	Echo, ECG/EKG, EEG	Last 5 Years
	Colonoscopy Reports	Last 10 Years
	Other:	

I understand that my health information may contain information relating to HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment or other conditions which may be specifically protected by law, and I authorize disclosure of that information. I understand that once the 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 that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by those regulations.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing at the address above, but if I do, it will not have any effect on any actions taken before the revocation was received. Unless revoked, this authorization expires 1 year from the date signed.

I understand that I may refuse to sign this authorization and that my treatment or payment for my treatment will not be affected unless my treatment includes research, or the reason for my treatment is to disclose the information to another person.

I authorize the use or disclosure of the record information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____

Signature of Patient/Patient Representative **Date**

_____

Print Name of Patient/Patient Representative **Relationship to Patient**