

**Wichita Surgical Specialists, P.A.**  
**DBA Mid-Kansas Ear Nose and Throat**  
**Protected Health Information Disclosure Authorization Form**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

CHECK ONE:

\_\_\_\_\_ I hereby authorize WICHITA SURGICAL SPECIALISTS, P.A. (WSS) to disclose PROTECTED HEALTH INFORMATION concerning the above named person to:

\_\_\_\_\_ Fax Number: \_\_\_\_\_  
Name(s) of person(s) or organization(s) to which disclosure is to be made.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_ I hereby authorize \_\_\_\_\_ to disclose PROTECTED HEALTH INFORMATION concerning the above named person **to WICHITA SURGICAL SPECIALISTS, P.A., 310 S Hillside, Wichita, KS 67211 Fax: 316-684-3326**

For treatment date(s): \_\_\_\_\_

Reason for disclosure: \_\_\_\_\_

Type of Information to be released:

\_\_\_\_\_ Entire Record (will not include billing records or records not prepared by or on behalf of WSS unless items specifically requested).

\_\_\_\_\_ Other Specific Information: \_\_\_\_\_

This authorization shall remain in effect for 60 days from the request unless otherwise specified expiration date: \_\_\_\_\_

I understand that the records to be disclosed pursuant to this authorization may contain \_\_\_\_ records relating to participation in any federally assisted drug and alcohol abuse program; \_\_\_\_ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); \_\_\_\_ information relating to HIV testing, HIV status or AIDS. I understand such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. 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 described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to \$15 per request, a copying charge of up to \$0.50 for the first 250 pages and \$0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Wichita Surgical Specialists, P.A.'s Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Privacy Officer, Wichita Surgical Specialists, P.A. DBA Mid-Kansas Ear Nose and Throat, 310 South Hillside, Wichita, KS, 67211.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Legal Guardian)

Printed Name: \_\_\_\_\_  
(Patient or Legal Guardian)