Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**
Provider's Name:	**Recipient's Name:** WesleyCare Family Medicine Center		
Provider's Address:	**Address 1:** 850 N Hillside	Fax: 316-962-3136	
	Address 2:	**Recipient's Phone:** 316-962-3070	
	City: Wichita	**State:** KS	**Zip:** 67214

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Instructions to Complete the
HIM Authorization For Use or Disclosure of Protected Health Information (PHI) form

REQUESTING RECORDS BE SENT TO WFM

Many facilities like you to use their release of information when requesting records so you may want to check before completing our form. Records will not be released if the form is not filled out correctly. Please follow the directions carefully and complete each step. INCOMPLETE RELEASES WILL BE RETURNED!

SECTION A:

Complete the **patient name**, **date of birth**, and **phone number** at the top of the page.
Under **Provider's Name** please write the name of who will be sending your records to us and include the address and phone number.
Under **Recipient's Name** – WesleyCare Family Medicine Center – 850 N Hillside – Wichita KS 67214

Under **Request Delivery** – leave blank for a paper copy.

Under **this authorization will expire on the following**: please write in MM/DD/YYYY format **ONE YEAR FROM TODAY'S DATE.**
Under **Purpose of disclose**: write "continuity of care"
Under **Description of information to be used or disclosed:**

- If you want us to receive behavior health records you will need to complete a separate release for those records and in this area check the appropriate boxes.
- If you want us to receive your past medical information please mark "**All PHI in medical record"**
- If you want us to receive only a portion of your records please select the appropriate boxes or write beside "**Other:**" what you would like us to receive.
- Under the Date(s) columns, **please write**: "All"

Read and initial the acknowledgement in the middle of the release.

SECTION B:
We have completed this section for you, please skip to section C.

SECTION C:
Read, make sure you **sign and date**, print your name and complete the relationship to the patient area.

If you have any questions please call our office at 316-962-3070.