AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____

Address _____

SS# _____ Phone _____

I hereby authorize _____ to disclose my protected health information.

I understand this is voluntary.

I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

I understand that if the person or organization listed below is not a health care plan or provider, federal privacy laws may no longer protect the released information.

I understand I may revoke this authorization at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization. Instructions on how to revoke this authorization are included in Dr. Valerie Drake-Albert's Notice of Privacy Practices.

Information to be released:

- ☐ Copy of complete health record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Diagnostic testing, including lab and X-ray
- ☐ Operative Report
- ☐ Other _____

Information to be released to **Dr. Valerie Drake-Albert, 8100 E 22nd St N Bldg 2200-2**

Wichita, Ks 67226, Ph: 316-440-8383 Fax: 316-440-8163.

Purpose of disclosure: _____

Signature of Patient or Representative _____

Date of Authorization: _____