KAW VALLEY HEARING

1520 Wakarusa Drive, Suite B
Lawrence, KS 66047
785-856-4200
www.kawvalleyhearing.com

AUTOHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Please print all information except for signatures

(Patient Name) _____ born on _____ , herby authorizes (or the patient's personal / authorized representative authorizes) the disclosure of records by Kaw Valley Hearing to:

☐Me (Patient or personal / authorized representative only. Must provide proof of relationship.)
☐Other / Facility (List full name and address) _____
_____

☐I authorize _____ to release the below indicated medial reports to Kaw Valley Hearing.

Please Check All Boxes Which Apply

☐Clinic Notes ☐Lab Tests ☐Medications ☐ Consultation Reports ☐Operative Reports
☐Billing Records ☐Psychological Reports ☐Radiology Reports ☐Diagnostic Studies
☐Specific Dates from: _____ to:_____ (this helps to ID your specific request)
☐Complete Medical Record or treatment provided at Kaw Valley Hearing
☐Other (Please specify): _____
_____

(If you have any questions as to what is included in any of the above categories, prefer an electronic copy of any electronic records, or do not want a specific report released, please let us know at the time of submission.)

The purpose of this request is: ☐Continued Care ☐Insurance/Disability* ☐Litigation* ☐Personal* ☐ Other*: _____

*** Kaw Valley Hearing Copy Charges: $10.00 Base Fee plus $0.50 per page**

- I understand once the above records are disclosed, they may be re-disclosed by the recipient and may no longer be protected by State and/or Federal Privacy Laws.
- My treatment cannot be conditional upon completing this authorization form, unless the treatment is for the sole purpose of creating information for discloser to a third party.
- I understand that I may revoke this authorization in writing by notifying th original recipient of this authorization at any time except to the extent that action has been taken in reliance on it.

SPECIFY THE DATE, EVENT, OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES: _____
(In all cases this 'Authorization' will expire one year from the date listed below)

SIGNED THIS _____ DAY OF _____, 20_____

_____ _____
Drivers License Number State

_____ _____
Signature of Patient or Authorize Representative Printed Name of Patient/Representative & Relationship

_____
Address: Street # City State Zip

_____
Daytime Phone Number