AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth: _____

Address: _____

Phone:_____ E- Mail Address: _____

I hereby authorize,_____[practice name]

at_____[address]_____[phone]

to release the medical information described below to Cerner Health Connections, Inc. d/b/a Healthe Clinic.

This Authorization applies to the following information [mark those that apply]:

- ❑ Any and all records in the possession of above mentioned entity, including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released.]
- ❑ Records regarding the following condition or injury_____which occurred on or about _____.
- ❑ Records covering the period of time_____to_____.
- ❑ Other [please specify – include dates]_____.

My protected health information may be used or disclosed under this Authorization by the above listed persons/entities for the following purposes:

- ❑ Personal
- ❑ Transfer of care
- ❑ Continuation of care
- ❑ Other:_____

This Authorization expires on:_____.

How information is to be received:

- ❑ Fax to (816) 448-0020
- ❑ Mail to World Headquarters Clinic
- ❑ Mail to Realization Clinic
- ❑ Mail to Continuous Clinic
- ❑ Mail to Innovations Clinic

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

- I also understand that certain records/information may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol, drug treatment or communicable diseases, and, unless otherwise specifically indicated, I am requesting that any and all such protected records be released under this Authorization.
- I know I may refuse to sign this Authorization and that my treatment, payment for my treatment or my enrollment or eligibility for benefits will not be affected unless my treatment includes research or the reason for my treatment is to disclose information to another.
- I have read and understand this Authorization. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records/information upon presentation of a photocopy of this Authorization.

_____ _____

Signature of Patient/Personal Representative Date

_____

Relationship to Patient