



Center for Women's Health  
FOR WOMEN BY WOMEN

1855 N. Webb Rd. Wichita, KS 67206 316.634.0060 x103 316.634.0050 FAX www.cwhwichita.com

**PATENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize (Circle One): **Dr. Sharon Breit** **Dr. Karen Strecker** **Dr. Amy Short**

(Circle One): **Release My Records To** **Get My Records From**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Fax #: \_\_\_\_\_

Entire Record       Lab Results       Radiology Results  
 Office Notes       OP Reports       Other: \_\_\_\_\_

Purpose of Disclosure:  Currently Pregnant?    Other \_\_\_\_\_

**Copying Fees: If you are requesting a copy of your medical record for yourself, instead of having it sent to another physician- there is an \$18.11 labor fee, plus \$0.60 per page for the first 250 pages, and \$0.43 per page for additional pages. Physician to Physician is FREE.**

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the number above. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility checked above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. I understand that be given a copy of this authorization form, after signing. I understand that copying charges will be applied according to office policy.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Print Name of Patient/Representative

\_\_\_\_\_  
Patients Date of Birth

\_\_\_\_\_  
Patient's Social Security Number