

Otology / Neurotology
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WICHITA EAR CLINIC

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Audiology
CARMEN SCHULTE, M.A.
MELANIE D. RHORER, Au.D.
BAILEE FIELDS, Au.D.
MIKA SKILLEN, Au.D.
JAMIE BINNS, Au.D.

C.Y. SUELLENTROP, Administrator

Authorization for Release of Protected Health Information (PHI)

Patient Information

- Patient Name: _____
- Date of Birth: ____ / ____ / ____
- Phone Number: _____

Request Information

- Date of Request: ____ / ____ / ____

Authorization Direction (Select One)

I authorize **Wichita Ear Clinic** to disclose my protected health information to the individual/organization listed below.

I authorize the individual/organization listed below to disclose my protected health information to **Wichita Ear Clinic**.

Receiving / Disclosing Party Information

- Name of Individual/Organization: _____
- Phone Number: _____
- Fax Number: _____
- Address: _____

Information to be Released (Select all that apply)

Complete Medical Record Office Visit Notes Audiology Reports Imaging Reports Billing Records
Other (please specify): _____

Purpose of Disclosure

Continuity of Care Personal Use Insurance Legal Other (please specify):

Method of Delivery (Select One)

Mail Fax Secure Email Patient Portal In-Person Pickup

If applicable:

- Email Address: _____
- Fax Number: _____

Expiration

This authorization will expire on (check one): ____ / ____ / ____ Upon completion of this request

Acknowledgment & Signature

I understand that the records to be disclosed pursuant to this authorization may contain _ records relating to participation in any federally assisted drug and alcohol abuse program; _ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); _ information relating to HIV testing, HIV status or AIDS. I understand such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to \$15 per request a copying charge of up to \$0.50 for the first 250 pages and \$0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Wichita Ear Clinic, PA Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Medical Records,

Wichita Ear Clinic, PA, 9350 E Central Ave, Wichita, KS 67206.

Kansas-Specific Notice: Kansas law may provide additional protections for certain health information, including mental health treatment records and HIV/AIDS-related information. By signing this form, I acknowledge that I am authorizing the release of such information as indicated above, in compliance with applicable Kansas statutes and federal HIPAA regulations.

Patient/Legal Representative Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: ____ / ____ / ____

A copy of a government issued ID must accompany this request.

Completed forms can be faxed to 316-686-3624 or emailed to medicalrecords@wichitaear.com

Office Use Only

- Date Received: ____ / ____ / ____
- Processed By: _____
- Date Completed: ____ / ____ / ____

Adult and Pediatric Ear Disease and Surgery ♦ Hearing and Balance Disorders
Facial Nerve Disorders ♦ Hearing Aids ♦ Pediatric and Adult Cochlear
Implantation ♦ Congenital Ear Malformations ♦ Posterior Fossa Surgery
Skull Base Surgery ♦ Cyberknife ♦ Gamma Knife ♦ Related Allergy