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**AUTHORIZATION FOR THE USE AND DISCLOSURE OF  
 PROTECTED HEALTH INFORMATION  
 TO THE WOMAN'S PLACE, P.A.**

I, \_\_\_\_\_, born \_\_\_\_\_, consent to and authorize the following Physician and/or Facility to furnish to The Woman's Place, P.A.:

	( )
Please list Physician or Facility	Phone Number
	( )
Address	Fax Number
City, State, Zip Code	

the following medical records and information (please check information you want released):

<input type="checkbox"/>	Recent Gyn Visit	<input type="checkbox"/>	Pap Smear (s)
<input type="checkbox"/>	Lab work	<input type="checkbox"/>	Pelvic Sonogram(s)
<input type="checkbox"/>	Mammogram(s)	<input type="checkbox"/>	OB Records
<input type="checkbox"/>	Bone Density Scan	<input type="checkbox"/>	Operative Note from _____ (year)
<input type="checkbox"/>	Other		

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Patient SSN \_\_\_\_\_ (List From & To dates covered for records requested)

for the following purpose(s): \_\_\_\_\_ (list all purposes).

I specifically authorize the release of types of information initialed below:

<input type="checkbox"/>	Alcohol and drug abuse treatment	<input type="checkbox"/>	HIV Status or AIDS
<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Genetic Information

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: Jonathan Funk, HIPAA Privacy Officer, at The Woman's Place, P.A. This authorization expires on \_\_\_\_\_ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I authorize the release of my records relating to: (check one):

- \_\_\_\_\_ Treatment rendered prior to the date this authorization is signed
- \_\_\_\_\_ Treatment rendered both before and after the date this authorization is signed
- \_\_\_\_\_ Treatment rendered only after the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulations. A photo static copy of this authorization shall be considered as effective and valid as the original authorization.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

If Personal Representative, Relationship to Patient: \_\_\_\_\_

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 1272697 Rev 11/2005