KANSAS CITY
ORTHOPAEDIC INSTITUTE

HIPAA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize Kansas City Orthopaedic Institute to use and/or disclose my protected health information ("PHI") described below.

2. Authorization for release of PHI covering the period of healthcare (check one)
   { } from date_____ to date_____ OR
   { } all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   { } my complete health record (including records relating to mental health care, communicable diseases, HIV or Aids, and treatment of alcohol/drug abuse) OR
   { } my complete health record with the exception of the following information (check as appropriate):
      { } Mental health records
      { } Communicable diseases (including HIV and AIDS)
      { } Alcohol/drug abuse treatment
      { } Other (please specify):_____

4. In addition to the authorization for release of my PHI described in paragraph number 3 of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name	Relationship	Contact Number

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date:_____

Signature of Patient

_____ Date of Birth: _____

Print Patient Name