ICT INTERNAL MEDICINE AND PAIN MANAGEMENT

7329 W VILLAGE CIR, STE 100
WICHITA, KS 67205
PHONE: 316-260-6363 FAX: 316-260-6301

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I authorize the use and/or disclosure of the below named individual's health information.

Patient Name ______________________________

Date of Birth _____/_____/_____ Phone ______________________

Address ______________________________

City/State/Zip ______________________________

2. The following person or organization is authorized to MAKE the disclosure.

Name ______________________ Fax number ______________________

Address ______________________________

City/State/Zip ______________________________

3. The information may be disclosed TO and used by the following person or organization.

Name ICT INTERNAL MEDICINE AND PAIN MANAGEMENT Fax number 316-260-6301

Address 7329 W VILLAGE CIR, STE 100

City/State/Zip WICHITA, KS 67205

4. The type and amount of information to be disclosed is as follows:
   (Include Dates if appropriate)

   ________ Complete Health Record ________ Lab Results/X-Ray Reports

   ________ Physical Exam ________ Progress Notes/Visit Summary

   ________ Immunization Record ________ Other

5. I understand the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency disease (AIDS), or human immunodeficiency virus (HIV). It may also include information pertaining to behavioral or mental health services and treatment for drug or alcohol abuse.
6. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to ICT Internal Medicine and Pain Management.
7. 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.
8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   ______________________________.

Should I fail to specify an expiration, this authorization will expire in sixty (60) days. I understand that authorizing the disclosure of said health information is voluntary. I am able to refuse to sign this form. My treatment shall not be hindered should I choose to sign this authorization. I understand that I may inspect or copy the information to be sued or disclosed as provided in CFR 164.524. I understand that any disclosure carries the potential for an unauthorized re-disclosure and the information may not be protected by federal law. If I have any questions about the disclosure of my protected health information, I can contact ICT Internal Medicine and Pain Management.

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Signature of Patient or Legal Representative Date

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Printed Name of Representative and Relationship