ASHLEY CLINIC

P.O. Box 946 Chanute, KS 66720
Phone (620)431-2500 Fax (620)431-0914

Consent for release of confidential information

Patient Name: _____ **DOB:** _____ **Account #:** _____

Patient Address: _____

I hereby authorize Ashley Clinic to disclose protected health information to:
Name: NMRMC Family Medicine
Address: 505 S Plummer Ave Chanute, KS 66720
Telephone: 620-432-5588 Fax: 620-431-1192

for the following purpose(s):

☒ At the request of the patient/representative

Type of information to be released: (Check only applicable records to release)

- ☐ Billing Records
- ☐ Progress/Office Visit Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports (x-rays, sonograms, images, etc.)
- ☐ Cardiac Studies (EKGs, Holter Monitors, etc.)
- ☐ Physical Exams (work, school, sports, KAN Be Healthy, etc.)
- ☐ Procedure Reports (lesion removal, joint injections, etc.)
- ☐ Correspondence (Letters, etc.)
- ☐ Immunizations
- ☐ Ancillary Studies (spirometry, audiometry, etc.)
- ☐ Psychotherapy Notes
- ☐ HIV/AIDS Test Results
- ☐ Records related to participation in any federal assisted drug and alcohol abuse program
- ☒ Entire Record (will not include billing records or records not prepared by or on behalf of this facility unless those items also are selected)
- ☐ Records not prepared by or on behalf of this facility. This facility cannot be responsible for the completeness or accuracy of such records.
- ☐ Other _____

Dates of Service for Record Release: From: _____ To: _____

This authorization shall remain in effect until _____ at which time this authorization to disclose the identified health information expires. If no date is provided this authorization will expire one year from the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain:
1) records relating to participation in federally assisted drug and alcohol abuse programs _____ **(Initials)**
2) information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than those 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) _____ **(Initials)**
3) information relating to HIV testing, HIV status, or AIDS _____ **(Initials)**
I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my signature/initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

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 redisclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by giving written notification to the Privacy Officer at Ashley Clinic, LLC.

Signature of Patient: _____ or Patient Representative _____ Date: _____
Patient/Representative (print): _____ Relationship: _____
Witness: _____ Title: _____