Addendum B-1

Wamego Family Clinic

Authorization Form for Release of Protected Health Information

I hereby authorize **Wamego Family Clinic** to disclose my protected health information as describe below to the person or organization listed below.

I understand this authorization is voluntary. I understand that Wamego Family Clinic will not condition treatment or payment on my signing this authorization.

I understand that if the person or organization listed below is not a health care plan or provider, then Federal Privacy Laws may no longer protect the released information.

Information to be released (description, specific): **Medical Information**

Date of authorization: _____

Expiration date of event that ends the release: **Termination of Service with Wamego Family Clinic**

Information may be released to: _____
Name/Organization Fax/Phone Number

_____
Additional Name(s)

The purpose of the information release: **Communication**

_____ _____
Signature of Patient or Patient's Representative Patient's Name

_____ _____
Printed Name Address

_____ _____
Relationship to Patient Patient's Date of Birth

Witness: _____

****

FOR OFFICE USE ONLY:

I understand I may revoke this authorization at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization.

I may revoke the authorization at any time by sending a written request for revocation to:

Wamego Family Clinic / Attention: Manager
711 Genn Drive / Wamego, Kansas 66547

Date when authorization is revoked (if applicable): _____

Signature: _____ Date: _____

AD/7/13