LAWRENCE INTERNAL MEDICINE, P. A.
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Lawrence Internal Medicine, P. A. is required to obtain your authorization to disclose your protected health information (PHI) for purposes other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices prior to signing this information.

Patient Name _____

DOB _____ SSN _____

PHI – RELEASE FROM:

_____
Name

_____
Address

_____
City State Zip

_____
Phone Fax

EXPIRATION DATE OF AUTHORIZATION: _____
*If not noted, this authorization will expire 90 days from the date it was signed.

PHI – RELEASE TO:

Lawrence Internal Medicine, P. A
1440 Wakarusa Drive, Suite 300
Lawrence, KS 66049-3879
785-842-7200
(FAX) 785-842-9397
www.lawrenceintmed.com

☐ DR. DILLON
☐ DR. KIMMEL

RECORDS REQUESTED:

☐ All patient records* ☐ _____

☐ The last 3 years of patient records* ☐ _____

You may:

- Request to inspect or copy the information that Lawrence Internal Medicine, P. A. intends to disclose.
- Refuse to sign this Authorization.
- Revoke this Authorization at any time by delivering a written Revocation to Lawrence Internal Medicine, P. A., except to the extent that Lawrence Internal Medicine, P. A. has already released information in reliance on this Authorization.

Lawrence Internal Medicine may:

- Not require that you sign this Authorization to receive treatment.
- Assess appropriate and reasonable fees for the copying of such information. Such fees will comply with federal and state laws.

I have read the above information and authorize Lawrence Internal Medicine, P. A. to disclose the PHI to person(s) described herein. I understand that, by signing this document, I release and discharge Lawrence Internal Medicine, P. A. from any and all liability and will hold Lawrence Internal Medicine, P. A. harmless from any release made pursuant to this Authorization. I understand that if the person or entity that receives the described information is not a health care provider or health plan covered under federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

_____
Signature of Patient, Guardian or authorized representative Date

_____
Relationship to Patient

_____
Witness Date