Post Rock Family Medicine

Authorization to Release Medical Information

Effective Date 4/14/2003, Updated 4/30/2012

Post Rock Family Medicine is an amended Organized Health Care Arrangement agreement (OHCA) permitted to represent itself as such under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is comprised of Daniel J. Sanchez, MD, PA, LifeLine Family Medicine, PA, Prairie Star Family Practice, PA, Rooks County Health Center Clinic, and Solomon Valley Family Medicine, PA. This OHCA relates to clinic locations at 1210 North Washington, Suite B, Plainville, KS, 67663; 107 S. Spruce Street, Stockton, KS, 67669; and 505 Main Street, Palco, KS, 67657. These named corporations are not to be construed as one for any other purpose than HIPAA Privacy Rules.

Patient Identification

Name: _____

DOB: _____ SS#: _____

I understand that my health care provider and the staff of Post Rock Family Medicine (PRFM) will not disclose my Protected Health Information (PHI), including health status, care, or treatment plan to anyone without my approval.

Please list any family member or other who may be involved in coordinating your care or payment for care. Also, indicate what information may be shared with each individual.

Name	**Phone Number**	**Relationship to Patient**	**Types of Information**		
			ALL	Scheduling & Appointments	Medical
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Specific Instructions or Limitations: _____

_____

Password: _____ Please provide this password to any individual who may be involved in coordinating your care or payment for care. They will be asked this password before information will be released over the phone.

☐ I do not wish for my protected Health Information (PHI) to be released to anyone.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient/
Legal Representative: _____ Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to the address below:
Post Rock Family Medicine
PO Box 407
Plainville, KS 67663
If you have any questions please call Post Rock Family Medicine at (785) 434-2622