HUNTER HEALTH

PERMISSION TO DISCLOSE

Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524.

"The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice."

Failure to provide all information requested may invalidate this request.

Patient Name		
Date of Birth		☐ Patient is a Minor

Notice: Requesting Medical Records (PHI) From Our Office

Our office requires patients and their representatives to sign this Access Form directing information disclosures or copies of medical records to other individuals involved in their care.

OPTION 1: ALL RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will have full access to your protected health information, are able to request copies of your medical records (PHI) and may also have full patient portal access of your records.

NAME	PHONE NUMBER	RELATIONSHIP

OPTION 2: LIMITED RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will NOT have full access to your PHI. Sexual Health Information allowed to be withheld by state law must be withheld as well as Mental Health and Drug Use protected by Disclosure of Substance Use Disorder Patient Records: Title 42 of the Code of Federal Regulations (CFR). These persons will have the ability to request medical records (PHI) but will not be given access to the patient portal as our office is unable to segment records in the portal.

NAME	PHONE NUMBER	RELATIONSHIP

- I hereby give my consent for Hunter Health to disclose protected health information (PHI) about me to the person or persons listed above in the manner described.
- I understand that, if the person or entity receiving the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations.
- I may revoke my consent at any time, but I must do so in writing and submit it to the following address: Hunter Health, 527 N. Grove, Wichita, KS 67214. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this request. This Access Form does not have an expiration date.

I have read and agree to all of the above.

Signature of Patient or Personal Representative **Date**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Print name of Personal Representative **Relationship to patient**