Mirabile M.D.
BEAUTY, HEALTH & WELLNESS

4550 West 109th Street Suite 130 · Overland Park, KS 66211 · 913-541-9495· fax 913-338-1337

Authorization for the use and/or disclosure of protected health information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone number: _____

□ I hearby authorize Mirabile MD to send protected health information concerning the above named patient to:
□ I hearby authorize Mirabile MD to obtain protected health information concerning the above named patient from:

Doctor/Practice Name: _____

Address: _____

Phone/fax number: _____

□ This authorization is for the release of my entire medical record

□ This authorization is for the release of certain medical records

If so, please specify: _____

Reason for disclosure: _____

This authorization shall remain in effect until _____ (date) at which time this authorization will expire

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assissted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately; information relating to HIV testing, HIV status or AIDS. Iunderstand that such information is subject to special protections pursuant to law. I authorize PROVIDER to use or disclose records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of the authorization. I understand that if they 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 re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request and a copying charge for up to @0.63 for the first 250 pages and $0.45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Providers Notice of Privacy Practices by mailing or hand delivering written notification to the following person; (Privacy Officer at 4550 W. 109th St. Overland Park, KS 66211)

Date: _____ Signature of Patient/representative: _____

Name of representative/relationship: _____ Phone#: _____

Date:_____ Signature of Witness: _____