HEALTHY STRATEGIES FAMILY DOC, P.A. -- Mila Lee Means, M.D.
6611 E. Central Ave., Ste. E, Wichita, KS 67206-1937
Phone: (316) 858-1351 Fax: (316) 858-1355

Authorization to Use or Disclose Protected Health Information

Patient Full Name: _____ DOB: _____ SSN: _____
Address, City, State, Zip: _____

I authorize Healthy Strategies Family Doc, P.A. (HSFD) to:

☐ Release Healthcare Information To ☐ Obtain Healthcare Information From ☐Exchange Information With

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

The following communication or records are requested: *(Check all that apply)*

☐ All healthcare information in my medical record ☐ Verbal, telephone, or e-mail communication
☐ Healthcare information in my medical record relating to the following treatment, condition, or date(s) of treatment _____

_____

☐Other, please specify including date(s) _____

Protected Information – you may use or disclose healthcare information regarding testing, diagnosis, and treatment: *(Check all that apply)*

☐Sexually transmitted disease (including HIV) ☐Psychiatric disorders/Mental health ☐Substance Abuse

Reason(s) for this Authorization: *(Check all that apply)*

☐At my request ☐Assessment ☐ Continuity of Care ☐Coordination of Care ☐Other, specify_____

This Authorization Expires:

☐On this date _____ ☐ 12 months from the date signed
mm/dd/yyyy

I understand that I do not have to sign this authorization in order to receive healthcare benefits (treatment, payment, or enrollment). I understand that I may revoke this authorization in writing at any time. If so, it would not affect any actions already taken by Healthy Strategies Family Doc, P.A. based upon this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer covered by those regulations. I understand that fees may be charged for preparing and sending copies.

_____ _____
Signature Printed Name

_____ _____
Relationship to Patient Date