ASSOCIATES IN FAMILY MEDICINE
8940 State Avenue
Kansas City, Kansas 66112-1646

PF-3000 Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed by Associates in Family Medicine, P.A.

The information covered by this authorization includes:

Your Medical and/or Financial Records from Associates in Family Medicine, P.A.

Purposes of Disclosure by Associates in Family Medicine, P.A.

Information listed above will be disclosed for the following purposes:

Assist your family members in understanding your medical condition and assisting with your care

To obtain consent from your family members regarding your medical care if you are unable to give consent

And for all of the purposes outlined in our Notice of Privacy Practices

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Authorized Staff of Associates in Family Medicine, P.A.

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

_____
Name of person/relationship

_____
Name of person/relationship

_____
Name of person/relationship

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Associates in Family Medicine, P.A.**. You should contact the **Administrator** to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person to whom it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once **Associates in Family Medicine, P.A.** discloses it to another party.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, **Associates in Family Medicine, P.A.** will not deny you any treatment:

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient