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Neurologist/ Sleep Medicine

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Neurologist

Dana M. Winegarner, DO
Neurologist

Kenneth R. VanOwen, MD
Neurologist

Carolyn A. Karr, PsyD
Neuropsychologist

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Clinical Nurse Specialist
MS Certified Nurse

Arlene T. Engle, ARNP
Nurse Practitioner

John A. Hunter, PsyD
Institute Coordinator

Elizabeth J. Rowe, PhD, MBA
Senior Scientific Advisor

Rachel Williams, PhD
Research Scientist

Shane Jackson, DPT
Physical Therapist

Amy Nichols, DPT
Physical Therapist

Kelli Wong, DPT
Physical Therapist

Authorization to Use or Disclose Health Information

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

I authorize the use or disclosure of the above named individual's protected health information as described below. The following individual(s) or organizations(s) are authorized to make the disclosure:

_____
_____
_____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

- ☐ medication list
- ☐ prescriptions
- ☐ handwritten progress notes
- ☐ dictated progress notes
- ☐ diagnostic tests (specify which type and date if possible)
- ☐ date: _____
- ☐ type: _____
- ☐ lab results specify dates: _____
- ☐ MRI or other x-ray reports specify dates: _____
- ☐ insurance cards, insurance face sheet
- ☐ physicians' orders
- ☐ other (please describe): _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Rowe Neurology Institute
8550 Marshall Drive, Suite 100
Lenexa, KS 66214
913-894-1500 phone 913-894-1502 fax

This information for which I am authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other health care providers
- ☐ other (please describe): _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____	_____	_____(Relationship to Patient)
Signature of patient / legal guardian	Date signed	If Signed by legal representative
_____	_____	
Signature of witness	Date signed	

Sleep Center
Accredited by the American Academy of Sleep Medicine

Multiple Sclerosis Center
Proud member of the Consortium of Multiple Sclerosis Centers

Headache Center

Memory Loss Center

Tel: 913-894-1500
Fax: 913-894-1502
Web: www.neurokc.com

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