Underground Vaults & Storage, Inc.
707 E 33rd Street North
Wichita, KS 67219-4060
Fax: 316-832-9547

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Pursuant to 45 C.F.R. 164.508

To: **Underground Vaults & Storage, Inc.,** as custodian of the patient medical records of:

_____
Name of Health Care Provider/Physician/Facility/Medicare or Medicaid Contractor

_____
Street Address City State Zip Code

Re: Patient Name: _____
Date of Birth: _____ Social Security No:_____

The undersigned hereby authorizes the disclosure of the Patient's protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws,[2] subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I hereby authorize Underground Vaults & Storage, Inc., its agents and employees, as the custodian of my records, to disclose my protected health information to the following person(s) and/or organization(s):

Name(s) _____

Organization(s) _____

Address(es) _____

_____

1. All medical records (other than psychotherapy notes for which a separate authorization is required) including, but not limited to, office notes, history and physical, consultation notes, inpatient, outpatient and emergency treatment, clinical charts, reports, order sheets, progress notes, nurses notes, clinical records, treatment plans , admission records, discharge records, test results , correspondence, records received from other medical providers and all other information, records and materials relating to the Patient's care and treatment or the specific protected health information described below:
   _____
   _____
   _____

2. Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space): _____
_____

3. I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to Underground Vaults & Storage, Inc., stating that I am revoking my authorization to disclose health records, except to the extent protected health information has been released in reliance on this authorization. I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization.

4. Unless sooner revoked, this authorization expires on the date one year subsequent to the date of this Authorization. This Authorization is given in compliance with the consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been considered and expressly waived.

I have had the opportunity to read and consider the contents of this authorization and confirm that the contents are consistent with my direction.

_____ Dated: _____

Patient or Legal Representative Signature (See 45 CFR 164.508(c)(1)(vi)

Representative's Relationship to Patient
(See 45 CFR 164.508(c)(1)(iv)_____

Printed Name: _____

Address: _____

Telephone: _____Email: _____

Other Contact Information_____

Notes:

_____

1. Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

2. These laws apply to health plans, health care providers, and health care clearinghouses.