Health Ministries Clinic
COMMUNITY HEALTH CENTER

Health Ministries Clinic
720 Medical Center Drive
Newton, KS 67114
Tel: (316) 283-6103
Fax: (316) 283-1333

Health Ministries Clinic
126 Main St.
Halstead, KS 67056
Tel: (316) 835-3700
Fax: (316) 835-3701

Pine Street Dental Clinic
215 South Pine Street
Newton, KS 67114
Tel: (316) 283-6103
Fax: (316) 283-0543

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

| **PATIENT'S NAME:** | **BIRTH DATE:** | **ADDRESS:** |
|---|---|---|
| | | |

**I hereby authorize Health Ministries Clinic to ☐ Send / ☐ Receive my medical records.**

**To / From**

Clinic / Hospital: _____

Dr. Name: _____

Location / Address: _____

Phone Number: _____

Fax Number: _____

The purpose of the disclosure is: ☐ Continuation of Care ☐ Switching Providers ☐ Other: _____

**CHECK TYPE OF PROTECTED HEALTHCARE INFORMATION**

| ☐ Basic record (medication list, problem list, allergies, last 4 office visits, specialist notes, most recent lab work, Pap smear, mammogram, colonoscopy) | ☐ Entire medical records for specified date(s) of service:<br><br>From: _____ To: _____ | ☐ ONLY the following specific information: |
|---|---|---|

This authorization shall remain in effect until _____ *(date)* or _____ *(occurrence of specified event)* at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

☐ **Yes** ☐ **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the Medical Facility listed above.

☐ **Yes** ☐ **No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the Medical Facility listed above. I understand that the Medical Facility listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

- I, the undersigned, have read the above and authorize the disclosure of the health information as described.
- I understand that treatment is not conditional upon the execution of this authorization.
- I understand that if the 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 is 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, a copying charge of 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 written notice to the person listed as follows by mailing or hand-delivering written notification to the following: **Privacy Officer, Health Ministries Clinic, 720 Medical Center Dr., Newton, KS 67114**

_____/_____/_____ _____

*Date* *Signature of Individual or Individual Representative*

_____

*Printed Name of Representative* *Relationship* *Address and Telephone Number*

_____/_____/_____ _____

*Date* *Signature of Witness*

Reviewed 01/18