Health Ministries Clinic
COMMUNITY HEALTH CENTER

720 Medical Center Dr
Newton, KS 67114
Tel: (316)283-6103
MAIN FAX: (316)283-1333

DL/ID Number:____________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION FORM

ONE PER REQUEST

PATIENTS NAME	DOB	ADDRESS

Release information FROM:	Release information TO:
Hospital or Clinic: ______________________________	Hospital or Clinic: ___________________________________
Name: _______________________________________	Name: _______________________________________
Address: _____________________________________	Address: _____________________________________
City, State, Zip: _______________________________	City, State, Zip: _____________________________________
Phone: ______________________________________	Phone: ____
Fax: ____	Fax: ____

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

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 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 person(s) listed above.

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

Are there records you wish to exclude? ____

I, undersigned, have read the above and authorize the disclosure of such health information as described. I understand that:

- Treatment is not conditioned upon the execution of this authorization.
- 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 no longer protected by those regulations.
- 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 250pages 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 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* *Telephone Number*

____/_____/________ ____

Date *Signature of Witness*

FOR OFFICE USE ONLY:

PLEASE SELECT ALL THAT APPLY:		☐ **ONLY the specified dates/information:**
☐ **Pap**	☐ **Mammogram**	
☐ **Medication list**	☐ **Colonoscopy**	
☐ **Problem list**	☐ **Most recent imaging**	
☐ **Allergies**	☐ **Most recent lab work**	**From:**_______________ **To:** _________________
☐ **Last 4 office visits**		

This area is to ***only*** be filled out by a Health Ministries Staff member, if patient needed help filling out this form and patient or patient's legal representative is present.

_______________________________ _______________________________ ____________

HMC Staff Name (PRINT) HMC Staff Signature Date

Revised 2019-10