ONE PER REQUEST

Health Ministries Clinic
COMMUNITY HEALTH CENTER

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

# Authorization for Use or Disclosure of Protected Health Information (PHI)

**SECTION 1 – Patient Demographics**

First Name | Middle Initial | Last Name | Date of Birth

Name at the time of treatment (if different than above)

Street Address | City | State | Zip

**SECTION 2 – Identification of Entity/Persons/ Class of Persons authorized to receive PHI**

**Release Information FROM:**

☐ **Health Ministries Clinic**

Hospital or Clinic: _____

Name: _____

Address | City | State | Zip

Phone | Fax

**Release Information TO:**

☐ **Health Ministries Clinic**

Hospital or Clinic: _____

Name: _____

Address | City | State | Zip

Phone | Fax

**SECTION 3 – The purpose of this disclosure:**

☐ Continuation of Care
☐ Disability
☐ Insurance
☐ Litigation
☐ Switching Providers
☐ Other

**Specify dates of treatment:** ____/____/_____ **to** ____/____/_____

**SECTION 4 – Description of information to be used or disclosed:**

☐ **All Pertinent Records- including** those listed below:

☐ Colonoscopy
☐ Dental Imaging
☐ Imaging/Radiology
☐ Immunizations
☐ Lab Reports
☐ Last Office Visit
☐ Mammogram
☐ Medication List
☐ Optometry

☐ **ONLY the following specified information:** _____

**SECTION 5– Expiration**

**This authorization shall remain in effect until date of** _____ (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. Requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about genetic testing, behavioral or mental health services and treatment of alcohol and drug abuse.**

**SECTION 6 – Statement of Understanding**

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

**I understand that:**

- This authorization is voluntary and that I may refuse to sign it
- 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.
- I have the right to inspect the health information I have disclosed to be used or disclosed by this Authorization form.
- If I revoke this authorization, it will have no effect on disclosures already made in reliance on this Authorization
- 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
- I authorize the use or disclosure of the Protected Health Information as described. I have received a copy of this form.
- 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.

____/_____/_____ **Date**

_____ **Signature of Individual or Legal Individual Representative**

_____

**Printed Name of Legal Representative** | **Relationship** | **Telephone Number**