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 to Release Protected Health Information

SECTION 1 – Patient Demographics

First Name | Middle Initial | Last Name

Maiden Name or other name used | Date of Birth | Telephone Number

Street Name | City | State | Zip Code

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

Release Information FROM:

☐ **Health Ministries Clinic**

Facility:_____

Address | City | State | Zip

Phone | Fax

Release Information TO:

☐ **Health Ministries Clinic**

Facility: _____

Address | City | State | Zip

Phone | Fax

SECTION 3 –Purpose

At the request of the individual the purpose for this disclosure is:

☐ Continuation of Care

☐ Switching Providers

☐ Other: _____

SECTION 4 –Check description of protected health information to be used or disclosed

Most Recent Records (past **18** months)

☐ Colonoscopy
☐ Diabetic Eye Exams
☐ Mammogram
☐ Imaging
☐ Immunizations
☐ Lab Reports
☐ Wellness/Physical exams
☐ Medication List
☐ Other: _____

☐ **ONLY the specified information:** _____

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

SECTION 5– Expiration

This authorization shall remain in effect until the date of _____ (or occurrence of a 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.**

☐ **No** ☐ **Yes, I authorize the release of information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**

☐ **No** ☐ **Yes, I authorize the release of information regarding behavioral or mental health services, and treatment of alcohol and drug abuse.**

SECTION 6 – Statement of Understanding

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

- This authorization is voluntary, and 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 healthcare 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 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
- If I revoke this authorization, it will not affect disclosures already made in response on this authorization.
- I authorize the use or disclosure of the protected health information (PHI) as described above and may receive 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.

_____ _____/_____/_____

Individual or Legal Representative Printed Name | Date

_____ _____ _____

Individual or Legal Representative Signature | Relationship to Patient | Telephone Number