

Place Label Here

Name: _____

DOB: _____

Date: _____



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

ONE PER REQUEST

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:				Release Information TO:			
Facility: _____				Facility: Health Ministries Clinic _____			
Address	City	State	Zip	720 Medical Center Dr.	Newton	KS	67114
Phone				Address	City	State	Zip
				316-283-6103			316-283-1333
				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)

<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Imaging	<input type="checkbox"/> Wellness/Physical exams
<input type="checkbox"/> Diabetic Eye Exams	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Medication List
<input type="checkbox"/> Mammogram	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> 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.**

No **Yes, I authorize the release of information regarding reproductive health**

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