Heart of Kansas Family Health Care, Inc
1905 19th Street, Great Bend, KS 67530
Phone: (620) 792-5700 Fax: (620) 792-5742

RECEIVED BY:_____

Authorization to Obtain and/or Disclosure of Protected (Medical) Health Information

_____

Patient Last Name First Name MI Birth Date Phone#

INITIAL ONE: _____ I want records for MYSELF-**$30 FEE FOR PAPER, $6 FEE FOR CD**

_____I want records TO BE SENT TO-COMPLETE BELOW

_____I want records FROM-COMPLETE BELOW

Name: _____ Attn: Medical Records_____

Address: _____
Street Address City State Zip Code

Phone: _____ Email or Fax:_____

RECORDS I AM REQUESTING ARE:

(INITIAL WHAT YOU WANT)

DATES OF SERVICE:_____

___ Immunization Records
___ Pap Smear
___ Mammogram
___ Entire Patient Record (transfer? YES NO)
___ Health maintenance report
___ Past Medical history list
___Specific information : _____

RESTRICTIONS:

The information indicated will be disclosed and/or obtained unless there are specific restrictions noted here:

_____

_____

EXPIRATION (INITIAL ONE APPROPRIATE OPTION)

THIS AUTHORIZATION FOR DISCLOSURE AND/OR OBTAINING OF HEALTH INFORMATION MAY BE REVOKED BY BELOW SIGNEE AT ANY TIME UPON RECEIPT OF MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS AUTHORIZATION IS VALID UP TO A YEAR FROM THE DATE OF SIGNATURE (UNLESS INITIALED BELOW):

___ Upon completion of treatment/evaluation _____ On the following date:_____

I, _____, the client or authorized representative, hereby authorize

HEART OF KANSAS FAMILY HEALTHCARE to release or obtain these records.

SIGNATURE:

I acknowledge that certain information I am consenting to release is confidential and protected by Federal and State law. I acknowledge that, once disclosed, it may be subject to redisclosure by the recipient and no longer be protected by statutory limits. Provision of treatment will not be conditioned by failure to authorize and I am not obligated to sign this authorization. I am allowed the right to inspect or copy the information to be used or disclosed. (A copy of this authorization will be provided to me.)

_____ _____ _____
Date Client Name Printed Client Signature

_____ _____ _____
Date Responsible Party/Guardian Name Printed Responsible Party/Guardian Signature

(Specific relationship to client) _____ Telephone: _____