AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient to authorize disclosure to self or others

INCOMING

_____ _____

Patient-Full Name Phone Number

_____ _____

Date of Birth Current Address

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Physician Name/Office_____ **Phone Number**_____

Address_____ **Fax Number**_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

__Office/Visit Notes From(Date(s)):_____To(Date(s)):_____

__Lab/Path Results __ Immunization Record __X-Ray/Imaging Reports __ Operative Reports

__Other(please specify):_____

For the Purpose of:

__Continuation of Care(Transferring Complete Care) __Continuity of Care(Multiple Physician Care Team)

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: FAMILY CENTER FOR HEALTHCARE 785-462-6184 MAIN

Address: 310 E. COLLEGE DR., COLBY, KS. 67701 785-460-1490 FAX

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Family Center for Health Care, 310 E College Dr, Colby KS 67701, C/O Scott Focke. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition. If I fail to specify an expiration date, event, or condition this authorization will expire in six (6) months.
8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.
9. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
10. I understand any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules.
11. If I have questions about disclosure of my health information, I can contact the clinic's privacy officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative. Relationship to Patient Signature of Witness

Patient is entitled to a copy of this request