FAMILY CENTER FOR HEALTH CARE
at Citizens Health

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient authorizing the disclosure to himself or others

OUTGOING

_____ _____

Patient's Full Name | Phone Number

_____ _____

Date of Birth | Current address

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

Physician Name/Office FAMILY CENTER FOR HEALTH CARE **Phone Number** 785-462-6184

Adress 310 E COLLEGE DR, COLBY, KS 67701 **Fax Number** 785-460-1490

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

___ Office/Visit Notes From (Date (s)):_____ To (Date (s)):_____
___ Lab/Path Results ___Immunization Record ___ X/Ray/Imaging Reports ____ Operative Reports
__ Other (Specify)_____

For the Purpose of:

___ Continuation of Care (Transferring Complete Care) ___ Continuation of Care (Multiple Physicians Care Team)

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

Name: _____ Phone Number: _____

Address:_____ Fax Number:_____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit my written revocation to Family center for Health Care, 310 E College DR, Colby KS 67701 C / O Scott Focke. I understand that revocation will not apply to my insurance company when the law gives my insurer 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 do not specify an expiration date, event or condition, this authorization will expire in six (6) months.
8. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to secure treatment.
9. I understand that I can inspect or copy the information that will be used or disclosed, as provided in CFR 164.524.
10. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
11. If I have questions about the disclosure of my medical 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

The patient is entitled to a copy of this request.