361 Grant Avenue – Junction City, KS 66441
Phone: 785.238.4711 – Fax: 785.762.5573

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________

Previous Name: ______________________________ Social Security: ______________

Address: ____

City: ____________ State: _______ Zip Code: _______ Phone: ______________

I authorize Konza Prairie Community Health & Dental Center To

☐ **Release Health/Dental Care Information of the Patient Named Above To:**

☐ **Obtain Health/Dental Information From:**

Term:
This Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of ________, 200_.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:

Name: ____

Address: ______________________________ City: ______________ State/Zip ______

☐ **All Medical/Dental Records** ☐ **Complete Transfer of Care**

☐ **Specified:** ________________ ________________

1. You have the right to revoke this authorization in writing unless the Medical Records (PHI) have already been released or if otherwise prohibited by state or federal law.
2. Treatment, payment, enrollment or eligibility for benefits may not be a condition to release Medical Records (PHI). A signed authorization is a requirement in order for Medical Records (PHI) to be released.
3. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by above party and may no longer be protected by the federal HIPAA Privacy Rule. Konza Prairie CHC will continue to maintain the confidentiality of our patient's medical records (PHI) mandated by the federal HIPAA Privacy Rule.

Definition: Sexually transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

If medical records are released directly to the patient, a fee of $15.00 for the first 20 pages and $0.15 for each additional page applies

Patient Signature: ______________________________ **Date:** ______________

Witness: ______________________________ **Date:** ______________

If you are not the patient signing this form, what is your relationship to the patient?
_____ Legal Guardian _____ Parent of Minor _____ Power of Attorney