



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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME:	BIRTH DATE:	ADDRESS:
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I hereby authorize Health Ministries Clinic to Send / Receive my medical records.

To / From
 Clinic / Hospital: _____
 Dr. Name: _____
 Location / Address: _____
 Phone Number: _____
 Fax Number: _____

The purpose of the disclosure is: Continuation of Care Switching Providers Other: _____

CHECK TYPE OF PROTECTED HEALTHCARE INFORMATION

<input type="checkbox"/> Basic record (medication list, problem list, allergies, last 4 office visits, specialist notes, most recent lab work, Pap smear, mammogram, colonoscopy)	<input type="checkbox"/> Entire medical records for specified date(s) of service: From: _____ To: _____	<input type="checkbox"/> ONLY the following specific information:
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This authorization shall remain in effect until _____ (date) or _____ (occurrence of 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 this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

Yes **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the Medical Facility listed above.

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

- I, the undersigned, have read the above and authorize the disclosure of the health information as described.
- I understand that treatment is not conditional upon the execution of this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.
- I understand that 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.
- I understand that 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, 215 S. Pine St., Newton, KS 67114 or Health Ministries Clinic, 720 Medical Center Dr, Newton, KS 67114**

_____/_____/_____
 Date Signature of Individual or Individual Representative

 Printed Name of Representative Relationship Address and Telephone Number

_____/_____/_____
 Date Signature of Witness