Community HealthCare System
NE Kansas

☐Centralia	☐Frankfort	☐Holton	☐Onaga	☐St. Marys	☐Westmoreland
785-857-3334	785-292-4451	785-364-3205	785-889-4241	785-437-3734	785-457-9890
785-889-4258 Fax	785-889-4258 Fax	785-889-4258 Fax	785-889-4258 Fax	785-889-4258 Fax	785-889-4258 Fax

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

_____ _____ _____
Patient Name | Other Legal Names Used | Birthday

_____ _____ _____
Patient Address (Street, City, State, Zip Code) | Social Security Number | Telephone Number

RELEASE FROM:

_____
Name of person, company or organization

_____
Address

_____
City, State, Zip

_____ _____
Phone | FAX

RELEASE TO:

_____
Name of person, company or organization

_____
Address

_____
City, State, Zip

_____ _____
Phone | FAX

The following information is to be disclosed: (please check)

____Lab Reports ____X-ray/imaging Reports ____ Path Report ____Operative/Procedure Report ____Clinic Visits

____Vaccine Record ____Emergency Room Reports ____History & Physical ____Discharge Summary ____Complete Record

____Other, please specify:_____

For health care services provided on (dates):_____

Purpose of this request:_____

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.
Expiration: This authorization expires one year from signature date unless I have indicated otherwise: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by Federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524
If I have questions about disclosure of my health information, I may contact Health Information Management at 785-889-5027.

_____ _____
Signature of Patient or Legal Representative | Date

_____ _____
If Signed by Legal Representative, Relationship to Patient | Phone Number

_____
Legal Representative's Address (Street, City, State, Zip Code)

*** **Please present a photo ID to the Health Information Clerk upon submission of this form**.