AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize/request this patient's records be released:

Patient Name: ______________________ Patient DOB: ______________

Also known as (optional): ______________________

Release records from:

☐ Jail Health Services (JHS) ☐ KC Medic One ☐ Public Health Clinic (write in clinic): ______________

☐ Other: ______________________

Release records to:

Name	Company (if applicable)	
Phone Number	Email	
Fax Number	Street Address	City/State/Zip

Record Dates: ______________________

If no date given: (non-KC Medic One requests): last 2 years or most recent jail stay will be released.

Record Types:

☐ All Medical Records (visit notes, medications, labs, diagnoses, test results)

☐ Vaccination Records ☐ Dental Records ☐ X-ray Images ☐ Billing Records ☐ Other: ______________

☐ KC Medic One Records:
Address or cross street of KC Medic One care: ______________
Time and date of KC Medic One care: ______________

Purpose of Request: ☐ Legal ☐ Payment ☐ Health Care ☐ Other: ______________

I understand that these records may contain information regarding Sexually Transmitted Disease (STD) and HIV/AIDS testing, diagnosis, and/or treatment, Substance Use Disorder (SUD), i.e. drug and/or alcohol abuse evaluation, diagnosis and/or treatment, and Mental Health information <u>unless</u> I check a box or boxes below.

Do NOT include the following information:

☐ STD/HIV/AIDS Testing/Diagnosis/Treatment ☐ SUD Evaluation/Diagnosis/Treatment ☐ Mental Health Information

This authorization/request is valid until this date or event: ______________________

If no date/event given, or records are for patient's employer or financial institution for non-payment purposes: authorization expires in 1 year.

Patient or Authorized Adult Signature	Authorized Adult Relationship to Patient	Date
Interpreter		Date

<u>Notice:</u>

You may revoke (take back) this authorization at any time by telling Public Health in writing you are revoking the authorization. The revocation will not apply to any records already released. Public Health may not refuse treatment, payment, enrollment, or eligibility for benefits just because this form isn't signed. The person or organization receiving the requested records may release them to others depending on applicable laws. You may have a copy of this form.

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Compliance Office

Client Name: ______________

HR #: ______________

D.O.B.: ______________

Distribution: **White – Health Records**