KC CARE HEALTH CENTER

Health Information Release Form

Please complete this form if you would like KC CARE to send or request your health information to or from another entity.

Patient Name:_____ **Date of Birth** (MM/DD/YYYY): _____

Release covers the dates of service:

From (MM/DD/YYYY):_____ to (MM/DD/YYYY): _____

I authorize the following information to be released from my medical or dental record(s) and/or shared with the person or organization designated below (Please check all of the boxes that you want to have released)***:***

☐ Entire Record ☐ Behavioral/Psychiatric ☐ Radiology Report ☐ Alcohol / Drug Treatment
☐ History & Physical ☐ Laboratory Report ☐ Consultation ☐ HIV Related Information
☐ Discharge Summary ☐ Progress Notes ☐ Office Notes ☐ Other (*specify*): _____

Reason for requesting information:

☐ Legal ☐ Personal ☐ Insurance ☐ Continuation of Care
☐ Other (*specify*): _____

Send my protected health information to, or share with:

Name/Title:_____ Organization: _____

Phone: _____ Fax: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Request my protected health information from:

Name/Title:_____ Organization: _____

Phone: _____ Fax: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Patient/Guardian signature:_____ **Date**: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records at the Health Center. The written revocation must be signed by the patient who provided the consent. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked or noted above this authorization will expire one year from the date this authorization is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

This information has been disclosed to you from records protected by federal confidentiality rules (42C.F.R. part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Requests for copies of medical records or non-documented material may be subject to copying fees.