AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Provider Name:_____

Address:_____

Phone/Fax:_____

To disclose from the health records of:

Name:_____ Maiden or Previous Name:_____

DOB:_____ SS#:_____ Phone:_____

Address:_____

Dates of Service:
From (date):_____ To (date):_____

For the purpose of: Continuity of Care

To disclose to: **Family Medicine of Washington County**
an affiliate of Washington County Hospital
302 East Second
Washington, KS 66968
Phone: 785-510-6111 Fax: 785-325-2277

The following information may be released: (please indicate the types of records that may be released (i.e. physician's notes, laboratory reports or all medical records)

_____

_____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.
2. 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 and present my written revocation to Family Medicine of Washington County, 302 East Second, Washington, KS 66968. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Unless otherwise revoked or specified, this authorization will expire on the following date, event or condition: If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
4. 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.
5. As a patient, I have the right to access my treatment records. Copies of records may be obtained with reasonable notice and payment of copying costs.
6. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan or healthcare clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.
7. If I have questions about the disclosure of my health information, I can contact the clinic's privacy officer.
8. I understand that due to Family Medicine of Washington County's affiliation with Washington County Hospital that all records received by FMWC will also be accessible to WCH.

_____ _____

Signature of Patient/Representative and Relationship Date Signed

Expiration Date:_____