KONZA PRAIRIE Community Health Center

Pharmacy
361 Grant Avenue
Junction City KS
785.579.6146
866.533.3613

LOCATIONS

Junction City
361 Grant Avenue
Junction City, KS 66441
785.238.4711
Medical: 866.309.8893
Dental: 877.671.5661

Manhattan
Tecumseh Road, Suite 100
Manhattan, KS 66502
785.320.7134
Medical: 866.807.7393
Dental: 866.534.5933

Chapman
111 East 5th Street
Chapman, KS 67431
785.922.6308
Medical: 866.309.8893

Authorization To Release Healthcare Information

Patient's Name:_____ DOB:_____

Previous Name:_____ SSN:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Phone Number #:_____

I authorize Konza Prairie Community Health Center to:

☐ Release health/dental care information of the patient named above to:

☐ Obtain health/dental information of the patient named above from:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

☐ All medical/dental records ☐ Complete transfer of care ☐ Specified:

Term: This authorization will remain in effect:

☐ From the date of this authorization until: ☐ Until the provider fulfills this request ☐ Until the following event occurs:

_____ _____

1. You have the right to revoke this authorization in writing unless the medical records (PHI) have already been released, or if otherwise prohibited by state or federal law.
2. Treatment, payment, enrollment, or eligibility may not be a condition to release medical records (PHI). A signed authorization is a requirement in order of medical records (PHI) to be released.
3. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the above party and may no longer be protected by the federal HIPAA Privacy Rule. Konza Prairie Community Health Center will continue to maintain the confidentiality of our patient's medical records (PHI) mandated by the federal HIPAA Privacy Rule.

Definition: ***Sexually transmitted diseases (STDs), as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus (HPV), wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.***

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

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

If you are not the patient signing this form, what is your relationship to the patient? ☐ Legal Guardian ☐ Parent of Minor ☐ Power of Attorney