

LOCATIONS

Junction City 361 Grant Avenue Junction City, KS 66441 © Clinic: 785.238.4711

© Pharmacy: 785.579.6146

© Medical: 866.309.8893

다 Dental: 877.671.5661 다 Pharmacy: 866.533.3613 Manhattan 222 North 6th

222 North 6th Manhattan, KS 66502 Clinic: 785.320.7134

© Pharmacy: 785.706.9833
 Medical: 866.807.7393

☐ Dental: 866.534.5933 ☐ Pharmacy: 866.562.9957 Chapman
111 East 5th Street
Chapman, KS 67431

© Clinic: 785.922.6308

☐ Medical: 866.309.8893

		AUTI	HORIZATION TO RELEASE HEALTHCARE IN	IFORMATION
			PATIENT DEMOGRAPHIC INFORMAT	
Patient'	s Name:			DOB:
Previou	s Name:		Address:	
City:			State:Zip Code:	Phone Number:
			AUTHORIZATIONS	
		Community Healt		□ Printed/mailed Copy of Record
☐ Rel	ease health/den	ital care informat	on of the patient named above to:	□ CD Copy of Record
☐ Obtain health/dental information of the Name:		al information of	•	(Labor and Material Charges Apply) Fax Number:
				
				Zip Code:
□ AII	medical/denta	l records	☐ Complete transfer of care	☐ Specified
		will remain in effe		request Until the following event occurs:
	om the date of t	this authorization		
□ Fr ——	om the date of t	this authorization	until: Until the provider fulfills this r	ect one year from the signature date.
□ Fr —— I. You h	Note: Unless nave the right to rwise prohibited	this authorization s marked otherw revoke this authority by state or feder	until: Until the provider fulfills this rise, this authorization will remain in effective prization in writing unless the medical recal law.	ect one year from the signature date. cords (PHI) have already been released, or if
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If you are not the patient, what is your relationship to the patient?

Legal Guardian Parent of Minor Power of Attorney