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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Term:**

This authorization will remain in effect:

- From the date of this authorization until the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**Until the provider fulfills this request.**

- Until the following event occurs:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I authorize Konza Prairie Community Health & Dental Center to:**

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

Obtain health/dental information from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

All medical/dental records     Complete transfer of care     Specified: \_\_\_\_\_

- 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.
- Treatment, payment, enrollment, or eligibility for benefits may not be a condition to release medical records (PHI). A signed authorization is a requirement in order for medical records (PHI) to be released.
- 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 & Dental 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 gonorrhoea.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	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 the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
<input type="checkbox"/>	Yes	<input type="checkbox"/>	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

\_\_\_\_\_  
 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