KONZA PRAIRIE Community Health & Dental Center

Junction City Medical
361 Grant Avenue
Junction City, KS 66441
Ph: 785.238.4711
Fax: 866.309.8893

Junction City Dental
361 Grant Avenue
Junction City, KS 66441
Ph: 785.238.1829
Fax: 877.671.5661

Manhattan Medical
2030 Tecumseh Rd.
Manhattan, KS, 66502
Ph: 785.320.7134
Fax: 866.807.7393

Manhattan Dental
2030 Tecumseh Rd.
Manhattan, KS, 66502
Ph: 785.320.7134
Fax: 866.534.5933

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: _____

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 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.
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 & 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 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 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 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