Family Care Center
1305 E 19th Ave
Winfield, KS 67156-5201
620-221-9500
Medical Record Release Form

Patient Name: Patient's Date of Birth:
Patient Address:
Patient Phone:

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following person, facility, or classes of persons are authorized to make the disclosure:
Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Fax: _____ Phone: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
_____ Complete Medical Record _____ Medical Record (From ____ to ____)
_____ Physical Exam _____ Lab Results (From ____ to _____)
_____ Immunization Record _____ X-Rays (From _____ to _____)
_____ Other (please specify): _____

4. 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 treatment for alcohol and drug abuse.

5. The following person, facility, or class of persons are authorized to receive the identified health information:
Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Fax: _____ Phone: _____
For the purpose: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present it to the address above. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
_____

7. If I revoke this authorization, it will have no effect on actions already taken in reliance upon this form.

8. If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.

9. I understand that if the person or entity that received the described health information is not a health care provider or health plan covered by federal privacy regulation, the health information may be re-disclosed and no longer protected by such regulations.

10. Questions about this disclosure, contact: Privacy Officer, 1305 E 19th Ave, Winfield, KS 67156, (620)221-9500.

Signature of Patient/Representative: _____

Relationship to Patient: _____

Date: _____