CITIZENS HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Legal Name: _____ Date of Birth: _____

Social Security # _____ Phone # _____

REQUEST FROM (Releasing facility)	**RELEASE TO (Receiving entity)**
Name	Name
Address	Address
City State Zip	City State Zip
Phone Fax	Phone Fax

INFORMATION TO BE DISCLOSED

☐ Billing	☐ Entire Record	☐ Immunizations	☐ Radiology Report
☐ Clinic/Progress	☐ Emergency Room	☐ Lab Test Results	☐ Radiology Images
☐ Consultations	☐ Medication/Pharmacy	☐ Mental Health	☐ Other_____
☐ Discharge Summary	☐ History & Physical	☐ Operative/Procedure	

Date(s) of Service From: _____ **through** _____

PURPOSE: ☐ Personal use ☐ Legal ☐ Claims Payment
☐ Continuation of Care (Transferring Complete Care) ☐ Continuity of Care (Multiple Physician Care Team)

SEND BY: ☐ Encrypted Email to: _____ ☐ Paper by US Mail
☐ Fax to: _____ ☐ Paper Pick-up

I **authorize** the releasing facility to disclose my individually identifiable health information as listed above. I understand that these records may include a diagnosis or reference to HIV or other contagious disease, genetic testing, mental health treatment, substance abuse or other conditions which may be specifically protected by law. I understand that once my health information has been disclosed, it will no longer be protected by federal privacy regulations and may be re-disclosed by the person receiving it. I understand that I may refuse to sign this Authorization form and that further treatment will not be affected if I do not sign unless my treatment includes research or the reason for my treatment is to disclose information to another person. A copy, fax or scan of this form is to be considered valid as the original and I acknowledge that there may be a charge for these records. I understand this consent expires **180 days** from the date of my signature unless I take back permission earlier. I understand that I can revoke this Authorization at any time except to the extent that action has already been taken to comply with it. To revoke this Authorization, contact the Citizens Medical Center Privacy Officer by writing at 100 East College Drive, Colby, KS 67701.

X_____ X_____
Signature of Patient or Authorized Representative Witness Signature

X_____ _____
Relationship with Patient (if applicable) Date

*If phone consent is obtained, please complete page 2 before granting release of records.
*If the patient is not picking up their own record, please have the responsible party sign on page 2.

Verification of Identity Process – This is required when a patient gives phone consent to release records. At least 2 identifiers are required before a record may be released.

Date of Birth _____

Driver's License Number _____

Last 4 digits of Social Security Number _____

Phone Number _____

Address _____

Responsible Party Receiving Records on Behalf of Patient –

Printed Name _____

Signature _____

Date _____

Submit the completed form to one of the following:

Mail:
Citizens Health
100 E. College Drive
Colby, KS 67701

E-mail:
him-staff@cmciks.com

or Fax:
785-460-1490

For questions call: 785-460-4851