CLAY COUNTY MEDICAL CENTER
Our Family. Caring for Yours.

CLAY CENTER • CLYDE
LINN • RILEY • GLASCO
FAMILY PHYSICIANS
Our Family. Caring for Yours.

AUTHORIZATION TO REQUEST HEALTH INFORMATION FROM OUTSIDE PROVIDER/FACILITY

Patient's Full Name_____

Birthdate _____ SSN _____

I authorize Clay County Medical Center, including Family Physicians clinics in Clay Center, Clyde, Glasco, Linn, and Riley, KS to request confidential health information from the below named provider/facility:

Provider/Facility _____

Fax Number _____ Phone Number _____

Address_____

City _____ State _____ Zip _____

The information to be disclosed is: (check appropriate box)

☐ All ☐ Other _____

For treatment date(s) of : ☐ **Previous 2 years** ☐ **Other:** _____

For the following purpose: ☐ Transfer of Care ☐ Continuity of Care ☐ Other _____

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be re-disclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I get a copy of this form after I sign it.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact: Privacy Officer, Clay County Medical Center, Clay Center, Kansas 67432

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____ _____
Relationship to Patient **Witness Signature**

This form shall remain valid for 365 days (ONE year) from the date signed.

Please send records secured to:
Fax: (785) 632-2221 Email: ROI@ccmcks.org Mail: CCMC HIM, PO Box 512, Clay Center KS, 67432