

Partners in Family Care

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McPherson office

1800 E Gordon St
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Authorization for Disclosure of Health Information

I authorize the release of the following information from the health records of:

Patient Name: _____ Date of Birth: ____/____/____
(Please Print)

Address: _____ City: _____ St: _____ Zip _____

Social Security Number: ____/____/____ Telephone #: (____) ____ - ____

Information to be disclosed:

(____) Complete Health Record (____) other records requested: _____ Lab Reports
_____ Radiology Reports
(____) OB Records _____ Consultation Reports
_____ History & Physical Examinations
_____ Discharge Summary
_____ Other not mentioned _____

***** If more than 10 pages PLEASE MAIL *****

For the purpose of: (____) Transfer Care (____) Continue Care
For the dates of: (____) 1st point of care, (____) Last 5 yrs, (____) Last 3 yrs
(____) Specific date: _____ and /or/ to _____

I request that the above information be sent: (Choose #1 or #2) (mark one)

#1. From: Dr. _____ Address: _____ City: _____ Ph or fax: _____	To: Partners in Family Care Fax: 620 345 6419 See mailing address above	<input type="checkbox"/> Inman <input type="checkbox"/> Moundridge <input type="checkbox"/> Hesston <input type="checkbox"/> McPherson
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#2. From: Partners in Family Care Fax 620 345 6419 See mailing address listed above	To: Dr. _____ Address _____ City _____
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Federal Law requires that you read and understand the following statement:

My medical health information MAY contain any of the following:

Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)

Behavioral or Psychiatric care

Alcohol and /or Drug Abuse treatments

I agree that any information contained in my medical record that pertains to any federally protected information is approved by me or my legal representative to release to the above named person/facility: _____

This information is to be disclosed for the purposes of continuing medical care only. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand this authorization may be revoked in writing at any time, except that action has already been taken in reliance of this authorization.

Signed: _____ Date: _____

Relationship to patient if not self: _____