FIRST care CLINIC

When You Need Health Care, Call First Care!

105 W. 13th St.
Hays, KS 67601
785.621.4990

208 Marc Wagner Dr.
Victoria, KS 67671
785.735.3710

www.firstcareclinic.com
Fax: 785.628.8719

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I hereby authorize and request First Care Clinic to disclose/obtain protected health information concerning the above-named patient to/from:

Name of Person or Entity: _____

Address of Person or Entity: _____

Phone #: _____ Fax #: _____

For the following treatment date(s): _____

For the following purpose: ☐ Treatment ☐ Payment ☐ Legal ☐ Other: _____

Information Authorized to be Disclosed

☐ Chronic Office Notes (last 4) ☐ Immunizations ☐ Radiology ☐ Referrals/Consults

☐ Lab Results (last 3 years) ☐ Med/Allergy List ☐ Preventative (Colonoscopy, Pap, Mammo)

☐ Dental Notes & X-rays ☐ Entire Record (will not include billing records) ☐ Other: _____

**I understand that the records to be disclosed may contain information relating to drug and alcohol dependency/abuse; mental or emotional conditions (psychotherapy notes are not included unless specifically requested; HIV testing, status, or AIDS.) Initial here if you do not wish this information to be disclosed: _____*

This authorization shall remain in effect until _____, at which time this authorization expires.
No later than one year from the date listed below.

I have read the above and authorize the disclosure as described. I understand that treatment is not conditioned upon this authorization. I understand that fees may be charged for preparing and sending records. I understand that information disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it or except as otherwise stated in FCC's Notice of Privacy Practices by submitting a written request to First Care Clinic – 105 W. 13th St. Hays, KS 67601.

Signature of Patient/Legal Guardian: _____ Date: _____

Printed Name of Legal Guardian: _____ Relationship: _____

Address and Phone # of Legal Guardian: _____

Signature of Witness: _____ Date: _____

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

COMMUNITY HEALTH CENTER FQHC QUALITY SM