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

Release To ☐ Requested From ☐

Name of person or Entity:_____

Address of Person or Entity:_____

Phone:_____Fax:_____

Patient information:

Name: _____

Address: _____

Phone: _____

Date of Birth: _____ Social Security Number:_____

Release the following Information (please check box)

☐ Immunization Records ☐ Most recent Pap Smear ☐ Mammogram ☐ Colonoscopy ☐ Dental Records ☐ Dental X-rays
☐ The Following time period _____to_____☐ Other: _____

The purpose of this authorization is: ☐ Continued Care ☐ Insurance/Disability ☐ Litigation ☐ Personal Reasons

A. ☐ I authorize the disclosure of all my PHI (Protected Health Information) for the above time period (which may include information about mental health care, Communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse)

B. ☐ I authorize the disclosure of all my PHI (Protected Health Information) for the above time except as noted
   - ☐ Do NOT disclose mental health records
   - ☐ Do NOT disclose communicable disease records (including HIV and AIDS)
   - ☐ Do NOT disclose alcohol/drug abuse treatment records
   - ☐ Do NOT disclose other records (please list): _____

This Authorization shall be in force and effective until _____, at which time this Authorization expires.

I understand that I have the right to revoke this Authorization at any time by submitting a written request to First Care Clinic, Inc., except to the extent that action has been taken in reliance on it. I understand that my treatment will not conditioned on whether I sign this Authorization. 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.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed name of Patient or Legal Guardian Witness