HEALTH DEPARTMENT

2507 Canterbury Drive, Hays, KS 67601

Medical Records Release

Authorization for the Use and Disclosure Protected Health Information

Patient Name: _____ Date of Birth:_____

Current Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I hereby authorize

_____
Print Name of Physician or clinic where records are kept

_____
Address

_____
City, State, Zip

_____ _____
Telephone Fax

to send my medical records to:

Ellis County Health Department
2507 Canterbury Drive
Hays, KS 67601
Phone: 785-628-9440
Fax: 785-628-0804

I authorize Ellis County Health Department to send my medical records to:

_____
Print name of Physician or clinic where records are to be sent

_____
Address

_____
City, State, Zip

_____
Fax

Records to be released:

- Most recent progress note or physical
- Immunization Record
- PAP results
- All treatment records

This authorization shall remain in effect until _____(date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Authorized Person Date