GEARY COMMUNITY HOSPITAL RURAL HEALTH CLINIC
PATIENT CONSENT AND AUTHORIZATION
FOR THE RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize:

_____

Name of person / Organization

_____

Street address, City, State, Zip code

To release my records to:

Geary Community Hospital Rural Health Clinic
Practice Management - Clinic Care Coordinator
1110 St. Mary's Road, Ste 400
Junction City, Kansas 66441
Fax: 785-210-3382

REGARDING:

Print Name _____ SSN _____ Date of Birth _____

The following information is to be released: **ALL RECORDS**

I understand that my records may contain information regarding the diagnosis or treatment of HIV (Aids), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

With my initials, I give my specific authorization for these records to be released:

____ HIV / Aids ____ Drug and Alcohol Treatment ____ Psychiatric Treatment

This information is released for the following purpose only. No other use or further disclosure of such information is permitted.

PURPOSE OF DISCLOSURE: ☐ Continuity of Care ☐ Transferring Care ☐ Other: _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. Additionally, I understand that this release may include information pertaining to: Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), psychiatric care, treatment for alcohol and/or drug abuse as documented in my medical records. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose.

THIS CONSENT TO DISCLOSE MEDICAL RECORD INFORMATION MAY BE REVOKED AT ANY TIME IN WRITING EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREIN. This consent expires 90 days from the date signed. I understand that treatment is not conditioned upon the execution of this authorization.

_____ _____

Signature of Patient Date of Consent

_____ _____

Signature of Legal Guardian Relationship to Patient