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**Authorization to Release/Discuss Confidential Medical Information to Specified Individual**

**(this form is to be filed in patient chart with information sheet)**

RELEASE OF MEDICAL RECORDS RELATING TO THE FOLLOWING MUST BE INITIALED TO BY PATIENT/PARENT/GUARDIAN - **“42 CFR Part 2 prohibits unauthorized disclosure of these records”**

\_\_\_\_\_\_\_\_**DRUG OR ALCOHOL TREATMENT** \_\_\_\_\_\_**PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT**

\_\_\_\_\_\_\_\_\_\_\_\_**HIV AND/OR AIDS STATUS** \_\_\_\_\_\_**OTHER PLEASE SPECIFY**

**Community Health Center in Cowley County**

**Treasure A. Wehner, D.O. Michelle R. Blair-Wunderlich, NP-C Daisy Matias, M.D.**

**Sharon Shepard, LSCSW Kesha Grace, LMSW**

**221 West 8th – P.O. Box 643**

**Winfield, Kansas 67156**

**620-221-3350**

The undersigned hereby authorizes you to discuss with, disclose or prepare and furnish a report of my medical condition(s), which may include any condition or care related to drug and/or alcohol dependency, psychiatric or psychological diagnosis, or HIV or AIDS status to the specified family members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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and also permit such person(s) to examine and receive a copy of any documents, records, pictures, or x-rays, under your control.

The information disclosed under this authorization may be subject to redisclosure by the recipient and will no longer be protected against disclosure.

It is acknowledged that this authorization is subject to be revoked upon written request at any time from the person whom is giving the authorization.

**Printed Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Or Signature of Representative and description of authority to act:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**