McPherson County Health Department
1001 N. Main St.
McPherson, KS 67460
(620)241-1753
Fax (620)241-1756

Authorization for Use and Disclosure of Protected Health Information

Client's Full Name	Date of Birth	Address

Check the applicable statement and complete the blank:

- ☐ I hereby authorize McPherson County Health Department to disclose protected health information concerning the above person to _____.
- ☐ I hereby authorize _____ to disclose protected health information concerning the above person to McPherson County Health Department.

Complete the following:

- ☐ For treatment date(s): _____
- ☐ For the following purpose(s): _____
  If the request is initiated by the individual completing the form, insert "at the request of individual"; otherwise, describe the purpose of the use and disclosure.

Check the type of information authorized to be used and disclosed:

- ☐ Demographic information
- ☐ Billing records
- ☐ Progress notes
- ☐ Test results
- ☐ Entire record (will not include billing records or records not prepared by or on behalf of McPherson County Health Department unless those items are also selected)
- ☐ Records not prepared by or on behalf of McPherson County Health Department who cannot be responsible for the completeness or accuracy of such records
- ☐ Other: _____

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 in effect for 60 days after the date signed below.

I understand that the records to be used and disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program. I understand that such information is subject to special protections under federal law. By my initials, I authorize the use and disclosure of records containing such information if they are otherwise included within the scope of this authorization. _____ (initial here)

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I understand that fees may be charged for sending copies of records, including a charge for supplies of up to $15.00 per request, a copying charge of up to $0.50 for the first 250 pages, and $0.35 for additional pages, and the reasonable cost of all duplication of records that cannot be routinely duplicated on a standard photocopy machine. If this authorization is for the sale of my protected health information, I understand that this authorization will result in remuneration to McPherson County Health Department. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to Hillery O'Brien, Office Manager, McPherson County Health Department, 1001 N Main St, McPherson, KS 67460.

_____ _____
Client's Signature Date

If the person giving this authorization is acting as the client's personal representative, complete the following information:

_____ _____
Personal Representative's Signature Date

_____ _____
Personal Representative's Printed Name Personal Representative's Relationship to Client

_____
Personal Representative's Mailing Address and Phone Number