Authorization to Release Health Information

Use this form to authorize Sedgwick County Health Center to release health information to you or to another person or organization.

1. Patient Information

Patient Name

Date of Birth

Medical Record # (if known)

Address

Phone Number

2. Who May Release the Information

I authorize Sedgwick County Health Center and its affiliated clinics, departments, and providers to release the health information described below.

3. Who Should Receive the Information

Name of Person / Organization

Address

Phone

Fax

Encrypted Email

4. Information to Be Released

Please check the information to be released:

- ☐ Entire Record
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Laboratory Results
- ☐ Imaging / Radiology Reports
- ☐ Immunization Record
- ☐ Medication List
- ☐ Billing Records
- ☐ Other:

Date(s) of Service or Date Range: From: To:

5. Sensitive Information

This authorization may include information related to the following, only if checked below:

- ☐ Behavioral health / psychiatric information
- ☐ Substance use disorder treatment information
- ☐ HIV/AIDS or sexually transmitted infection information
- ☐ Drug and alcohol information
- ☐ Other specially protected information:

6. Purpose of Disclosure

Please select the purpose of this disclosure:

☐ At my request ☐ Continuing medical care ☐ Insurance ☐ Legal ☐ Personal use ☐ Other:

7. Delivery Method

Please send the records by:

☐ Mail ☐ Pickup ☐ Fax ☐ Encrypted Email ☐ Other: ______

If email is selected, I understand Sedgwick County Health Center will use reasonable safeguards for transmission, but cannot control access to my email account or device after delivery.

8. Expiration and Rights

I understand that: **(1)** I may revoke this authorization at any time by submitting a written revocation to the Medical Records Department, except to the extent action has already been taken in reliance on this authorization. **(2)** I do not have to sign this form to receive treatment, payment, enrollment, or eligibility for benefits, except as otherwise allowed by law. **(3)** Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

This authorization will expire on: ______

If no date or event is listed, this authorization will expire one (1) year from the date signed.

9. Signature

Signature of Patient or Legal Representative	Date
Printed Name	Relationship to Patient (if legal representative)
Witness (optional)	Date