HEARTLAND
COMMUNITY HEALTH CENTER

Heartland Community Health Center
1312 W 6th St
Lawrence, KS 66044

Heartland @ Panda Pediatrics
1803 W 6th St
Lawrence, KS 66044

Heartland COVID-19 Clinic
346 Maine St, Suite 150
Lawrence, KS 66044

Authorization to Release and Disclose Patient Information

To treat you effectively, your provider needs to review your past medical records. For questions about transferring records to or from Heartland, contact Heartland's Health Information Management Department at 785-842-4477 Option 5.

Last Name:_____ First Name:_____ Middle Initial:_____
Other Names Used:_____ DOB:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Mobile Phone:_____

I hereby request access to the protected health information in my electronic health record for dates of service from (date):_____ to (date):_____ maintained or created by the provider named below to the recipient named below.

☐ Most Recent Medical Progress Notes
☐ Most Recent Dental Progress Notes
☐ Immunization
☐ X-ray Reports/Films
☐ Pathology/ Lab Reports
☐ Other: _____

☐ Record Set to Include:
- Last Three (3) Office Visit Notes, most recent lab results, medication list, immunization records, colonoscopy report, mammogram report, pap report, imaging completed within the past year, foot/eye exam and A1C (if applicable), list of any known specialists caring for the patient.

***Mental Health Records: A separate Authorization to Release/Request a patient's mental health notes must be completed to obtain additional records**

☐ **Mental Health Records (No other records may be requested on this form) ***

☐ I will pick up my records
☐ Fax my records
☐ Mail Copies of my records to the individual noted below

☐ Email my records: ***By selecting email option, although sent using encryption data software, the patient/recipient is aware this method may not be secure on the receiving end. However, they are accepting the risk.**

Records From	Records To
Name:	**Name**:
Address:	**Address**:
Phone:	**Phone**:
Fax/Email:	**Fax/Email:**

Purpose of Request: ☐ Patient's Request ☐ Insurance Dispute ☐Referral ☐ Moving and/or switching providers ☐ Seeing a Specialist ☐ Disability ☐Other:_____

I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature
- Heartland Community Health Center will not restrict my treatment if I choose not to sign this authorization
- A photocopy/fax of this authorization will be treated as an original
- Heartland Community Health Center records may include records that it received from other organizations. If these records have been used by Heartland and filed in the records Heartland maintains about you, these records could possibly be released with the patient's health records.
- Heartland cannot prevent re-disclosure of the patient's information by the person or organization who receives your records under this authorization, and that information may not be covered by state and Federal privacy protections after it's been released. By signing this authorization, you release Heartland from all liability resulting from a re-disclosure by the recipient.
- Re-disclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing. Other laws, however, may prohibit re-disclosure.
- *The information authorized for release may include protected health information or treatment notes related to mental health. Release of mental health records requires a separate ROI and may require consent of the treating provider or a court order.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE (This may include HIV Test Results, Substance Abuse/ Drug Abuse Records, Genetic Test Results)**
- ** Agreeing to have documents via secured email releases any/all liability from Heartland Community Health Center. Requester accepts all risks.**

_____ _____ _____
Signature Relationship to Patient Date

_____ _____ _____
Witness Relationship to Patient Date

Staff Initials: _____

Return Completed Form To:
Email: medrecords@heartlandhealth.org
Fax: 785-856-0375 **Mail:** Attn: Med Recs: 1312 W. 6th St. Lawrence, KS, 66044