HEARTLAND
COMMUNITY HEALTH CENTER

Heartland & River City Pharmacy
1312 W 6th St
Lawrence, KS 66044

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

Heartland Bluestem Wellness
534 Michigan St
Lawrence, KS 66044

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION HIPAA AND 42 CFR PART 2 AUTHORIZATION

RETURN COMPLETED FORM TO:
Email: medrecords@heartlandhealth.org
Fax: 785-856-0375
Mail: Attention: Medical Records
Heartland Community Health Center
1312 W 6th Street, Lawrence, KS 66044

Questions: (785) 727-2131

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Other Names Used: _____

AUTHORIZATION

I authorize the disclosure of my protected health information as described below:

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

**If records are going to be picked up, please write the name of the individual picking them up.*

INFORMATION TO BE USED OR DISCLOSED (check all that apply):

☐ Medical Office Visit Notes
☐ Dental Office Visit Notes
☐ Behavioral Health Visit Notes
☐ Immunizations
☐ Laboratory results
☐ Pharmacy records
☐ Substance use disorder treatment records (Part 2 Records)
☐ Entire medical record (All Office Visits, Immunizations, Lab Results, Pharmacy, SUD, Billing)
☐ Other (please specify**):_____

***Heartland does not maintain psychotherapy notes.*

DATE(S) OF SERVICE

Date(s) of Service: From: _____ To: _____

DELIVERY METHOD

☐ I will pick up my records. ☐ Mail my records to recipient address. ☐ Fax my records to recipient fax. ☐ Email my records via secure email to recipient email.

PURPOSE OF DISCLOSURE

☐ Treatment/Payment/Operations (Part 2 Records)
☐ Continuity of Care/Referral or Consultation
☐ Insurance/payment
☐ Legal
☐ Personal use
☐ Switching to a new Provider
☐ Other: _____

EXPIRATION

This authorization will expire on*: _____ or upon occurrence of the following event (please specify):

_____

**If no expiration date or event is listed, this authorization expires one (1) year from the date signed.*

PATIENT RIGHTS AND ACKNOWLEDGMENTS

I understand that:

1. I am not required to sign this authorization. My ability to receive treatment will not be conditioned upon signing this authorization, except as permitted by law.
2. I may revoke this authorization at any time by submitting a written notice to Heartland's Privacy Officer, except to the extent action has already been taken in reliance upon it.
3. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA, except where federal or state law otherwise limits redisclosure.
4. Medical records may include records relating to behavioral health care, communicable diseases, and HIV/AIDS. They may also contain information related to the diagnosis, treatment, or referral for treatment of a substance use disorder. Federal law protects these records.
5. I specifically authorize the disclosure of records relating to the diagnosis, treatment, or referral for treatment of a substance use disorder that are protected by 42 CFR Part 2, if I have selected "Substance use disorder treatment records" above.
6. The recipient may only use or disclose Part 2 records as permitted by applicable federal law.

REVOCATION OF AUTHORIZATION

Written revocations should be sent to: Privacy Officer, Heartland Community Health Center - 1312 W 6th Street, Lawrence, KS 66044 or via fax: 785-856-0375.

SIGNATURE

I have read and understand this authorization. I authorize the use and disclosure of my health information as described above. I authorize the use and disclosure of records protected under 42 CFR Part 2, including records relating to the diagnosis, treatment, or referral for treatment of a substance use disorder, as described in this authorization.

Signature: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, describe your legal authority (parent, legal guardian, health care power of attorney, executor, etc.): _____

Address:_____ ***Telephone Number:*** _____