Kansas Soldiers' Home
714 Sheridan – Unit 128
Fort Dodge KS 67843
(620)227-2121
FAX (620) 227-0107

Kansas Veterans' Home
1220 World War II Memorial Drive
Winfield KS 67156
(620) 221-9479
FAX (620) 229-9050

AUTHORIZATION TO RECEIVE AND RELEASE PROTECTED HEALTH INFORMATION

Resident's name: _____ SSN: XXX-XX-_____ DOB: _____

Authorizes

_____

_____

_____

To Disclose To

_____

_____

_____

___ Entire medical record for specific date(s) of service: From:_____ To: _____
___ ONLY the following specific information:

_____

_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

- Psychological/psychiatric conditions
- HIV/AIDS diagnosis and/or testing
- Drug and/or alcohol abuse diagnosis and/or treatment
- Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions:_____

The purpose of this disclosure is:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: upon my discharge from the Kansas Soldiers' Home, Fort Dodge, Kansas** or **the Kansas Veterans' Home, Winfiled, Kansas.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ Date _____
(Signature of resident or authorized Representative)

_____ Date _____
(Printed name of representative-relationship/capacity to Resident)

_____

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