Kansas Soldiers' Home
714 Sheridan – Unit 128
Fort Dodge KS 67843
(620)227-2121
FAX (620) 225-6331

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

Authorization for Use or Disclosure of Protected Health Information

Name of Resident: _____ DOB: _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the release of my protected health information for the following time period:

Beginning on: _____ And ending on: _____

The information is to be released to: _____

For the purpose(s) of: _____

I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on _____
Or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the facility, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at any time by providing the facility with my written notice of such revocation.

Date: _____ Signature of Resident: _____

Printed Name of Resident: _____

Date: _____ Signature of Representative: _____

Printed Name of Representative: _____

Relationship to Resident: _____

Date: _____ Signature of Witness: _____

Printed Name of Witness: _____

A copy of this record must be proved to the person making the request and a copy must be filed in the medical record.