Wamego Family Clinic
Authorization Form for Release of Protected Health Information

I hereby authorize _____ to disclose my protected health information as described below to the person or organization listed below.

I understand this authorization is voluntary. I understand that **Wamego Family Clinic** will not condition treatment or payment on my signing this authorization.

I understand that if the person or organization listed below is not a health care plan or provider, then Federal Privacy Laws may no longer protect the released information.

Information to be released (description, specific):
All medical records

Date of authorization: _____

Expiration date of event that ends the release:
Termination of Services with Wamego Family Clinic

Information may be released to:
Wamego Family Clinic, 711 Genn Drive, Wamego, Kansas 66547

Phone: **785-456-6288** **Fax: 785-458-7347**

The purpose of the information release: **Continuity of Care**

_____ _____
Signature of Patient or Patient's Representative Patients name

_____ _____
Printed Name Address

_____ _____
Relationship to Patient Patient's Date of Birth

Witness: _____

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FOR OFFICE USE ONLY:
I understand I may revoke this authorization at any time, unless the information has already disclosed pursuant to a valid authorization and before I have withdrawn my authorization.

I may revoke the authorization at any time by sending a written request for revocation to:

Wamego Family Clinic/ Attention: Clinic Manager
711 Genn Drive/ Wamego, Kansas 66547

Date when authorization is revoked (if applicable):_____

Signature: _____ Date: _____