LINCOLN COUNTY
PUBLIC HEALTH DEPARTMENT

"Healthy People Build Strong Communities"

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT FULL NAME_____

PHONE NUMBER_____ BIRTHDATE_____

ADDRESS_____

I,_____, understand that the Lincoln County Health Department collaborates with and refers patients to a network of programs that provide intervention services and exchanges information for the purpose of serving my child and our family. I authorize the Lincoln Co. Health Department to obtain and release information to and from the following (see checked boxes) for the purpose of: _____. Only the information needed for the agency to set up or continue follow up from a referral will be shared.

- ☐ Kansas Department of Children and Families (DCF)
- ☐ Hospital_____
- ☐ Parents as Teachers
- ☐ School District # _____
- ☐ Lincoln County Transportation Service
- ☐ Catholic Charities
- ☐ Kids First
- ☐ Lincoln Food Bank
- ☐ Other _____
- ☐ Case Worker_____
- ☐ Physician_____
- ☐ Audiologist_____
- ☐ Kan/Care _____
- ☐ Heart Choices
- ☐ WIC
- ☐ Healthy Start
- ☐ Becoming a Mom
- ☐ Mitchell Co. Partnership for Children (MCPC)

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

114 West Court Street, PO Box 187 Lincoln, Kansas 67455
Phone: 785-524-4406 Fax: 785-524-5003
e-mail : lchd@lincolncopublichealth.org website : www.lincolncoks.com

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of the at information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be re-disclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form, unless my treatment includes research, or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I may get a copy of this form after I sign it.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact: Lincoln County Health Department, 114 W. Court, Lincoln 67455. 785-524-4406

_____ _____

Signature of Patient or Patient Personal Representative Date