Kansas Veterans' Home
1220 World War II Memorial Drive
Winfield, KS 67156
620-221-9479

Kansas Soldiers' Home
714 Sheridan – Unit 128
Fort Dodge, KS 67843
620-227-2121

Authorization to Receive & Release Protected Health Information

_____	_____	_____
Name of Resident	Last 4 of Social Security Number	Date of Birth

Authorization for Use or Disclosure of Protected Health Information as required in the Health Insurance Portability and Accountability Act (45 CFR Parts 160 and 164).

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf to use and/or disclose the protected health information described below to the Kansas Veterans' Home for treatment, payment or healthcare operations. Additionally, I authorize release of my protected health information by the Kansas Veterans' Home for the same purposes.

1. ☐ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse.)
   OR
   ☐ I hereby authorize the release of my complete health record with the exception of the following:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol/Drug abuse treatment
   - ☐ Genetic Testing
   - ☐ Other (please specify): _____

2. This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. This authorization shall be in force and effective until 90 days after the date of my final discharge from the Kansas Veterans' Home or if the admission is not finalized, at which time this authorization expires.

4. I understand that I have the right to revoke this authorization, in writing, at any time by completing KVH form 03-021 *Revocation of an Authorization* and submitting it to the HIPAA Compliance Officer or designee. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5. I understand that by signing this authorization my treatment, payment, and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Signature of Resident or Personal Representative	Relationship to Resident	Date

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