



CLAY COUNTY  
**PUBLIC HEALTH CENTER**



**HIPAA - Request to Inspect & Authorization to Release PHI**

800 Haines Drive  
Liberty, MO 64068  
Revised: 12/2/19  
Form# 1.010.112.5F-2

Phone Number: 816-595-4322  
Medical Records Fax Number: 816-595-4399  
*There may be a fee for each record requested.*

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**I hereby authorize Clay County Public Health Center to:**

\_\_\_\_ **OBTAIN FROM** \_\_\_\_ **RELEASE TO** Records dated \_\_\_\_\_ to \_\_\_\_\_

Agency/Doctor/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Records to be transferred (check boxes to be released):

- |  |  |
|--|--|
| <input type="checkbox"/> TB Testing Results      | <input type="checkbox"/> Immunization Records  |
| <input type="checkbox"/> Pap Reports             | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> Medication History      | <input type="checkbox"/> Treatment Record      |
| <input type="checkbox"/> HIV Testing/STD Testing | <input type="checkbox"/> Other: _____          |

**Prohibition of Redisclosure:** This information has been disclosed from your records. Your confidentiality is protected by Federal Law. Federal regulations prohibit us from making any further disclosure of this information without further consent. Additionally, you understand that this release may include information relating to: Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency virus), psychiatric care, and treatment for alcohol and/or drug abuse. You hereby absolve said person, firm, agency, physician, nurse, clinic, or hospital from any liability for releasing such information pursuant to this authorization. The Clay County Public Health Center and its staff who provide professional service to you are authorized to use any personal information about you for treatment, billing or healthcare operations within the Health Center. The Health Center, as required by law, discloses all positive reportable communicable diseases to the State Department of Health.

The purpose of this release of information is at the client's or guardian's request. NOTE: A copy of this authorization is as valid as the original.

I understand that signing this authorization is voluntary and is not a condition of receiving services here or payment. This consent will automatically expire without my express revocation, after 12 months from the date of signature. I do not authorize further release to any third party.

Client/Guardian Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**FOR CCPHC USE ONLY**

Date Records Sent: \_\_\_\_\_ VIA:  Fax  Mail  Other: \_\_\_\_\_

Client Record #: \_\_\_\_\_ Scanned to Record \_\_\_\_\_ Employee Completing Request: \_\_\_\_\_

The mission of the Clay County Public Health Center is to deliver the essential public health services of prevention, promotion and protection to the communities of Clay County.