HIPPA Release Form

Patient Name:_____ Patient Date of Birth:_____

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used and disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that KCCHC reserves the right to change their notice and information practices and that I may obtain a revised copy of the notice by requesting one from the health center.

I have the right to revoke this consent by notifying KCCHC in writing, except to the extent that KCCHC has taken action in reliance on my consent.

List names of people that doctor/nurse practitioner can talk to about your health information:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

I understand that KCCHC will not discuss my medical care or billing information with anyone not listed on this account.

I understand that this consent supersedes any other consent that may have been signed.

_____	_____
Signature of Patient or Patient's Respresentative	Date
_____	_____
Printed Name of Patient or Patient's Representative	Relationship to Patient or Authority to act on behalf of the patient

KCCHC has my permission to leave a message on my contact phone numbers/answering machine or cell phone regarding my healthcare needs. ◉ Yes ○ No _____Initials

This consent will expire one year from date signed.

Created: 04/12/2024