



Health Department
Prevent. Promote. Protect.

Miami County Health Department

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Dr. Shalaunda Gray, MD – Medical Director/Local Health Officer

Christena R. Beer, MPH, BSN, RN – Public Health Director

Release of Information

Patient Name: _____

Date of Birth: _____

I do not authorize Miami County Health Department to release my medical information and prescriptions to anyone. I understand that there are exceptions to the confidentiality for the protection of myself and the public, which includes but is not limited to the following:

- Positive sexually transmitted infections may require reporting to Kansas Department of Health and Environment (KDHE) and follow up treatment.
- Positive laboratory results for certain tests may require reporting to KDHE.
- If, in the course of my visits to MCHD, a staff member thinks I may do harm to myself or someone else, the potential victim or authorities may be notified.

I authorize for Miami County Health Department to release my medical information and prescriptions to the following individual(s). (Fill out information below)

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

This consent is to be in effect until 1 year from date of signature. I understand that I have the right to revoke this consent in writing, except where there are disclosures in reliance in previous consents.

Printed Name of Patient/Parent/Legal Guardian/Representative

Signature of Patient/Representative

Relationship

Date