

HOSPITAL DISTRICT #1 OF RICE COUNTY; LYONS, KANSAS 67554

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME _____
OTHER NAMES USED _____
BIRTHDATE _____
TELEPHONE NUMBER _____

I, _____, authorize _____ to disclose confidential health information from the above-named patient's health information to [name] _____ for the following purpose: _____

The information to be disclosed is:

- Anesthesia Record
- Billing Records
- Consultation Reports/Records
- Emergency Department Records
- History/Physical/Discharge Records
- Laboratory Records
- Nursing Notes/Records
- Other (List hospital required tests here)
- Operative Reports/Records
- Pharmacy Records
- Physical/Speech/Occupational Therapy Records
- Physician Notes/Records/Orders
- Psychotherapy Notes (need separate authorization)
- Respiratory Therapy Records
- Social Work Reports/Records

for treatment dates of (need to include the date of the test that it was drawn) _____

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 that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed 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 will get a copy of this form after I sign it.

This authorization will expire on the following date or event: _____

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:

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Relationship to Patient