



MEDICINE LODGE MEMORIAL HOSPITAL & PHYSICIANS CLINIC

710 North Walnut
Medicine Lodge, Kansas 67104
(620) 886-3771

Kevin A. White, Administrator

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME _____

OTHER NAMES USED _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

TELEPHONE NUMBER _____

I, _____, authorize *Medicine Lodge Memorial Hospital & Physician's Clinic* 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:

- | | |
|-------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Anesthesia Record | <input type="checkbox"/> Operative Reports/Records |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Pharmacy Records |
| <input type="checkbox"/> Consultation Reports/Records | <input type="checkbox"/> Physical/Speech/Occupational Therapy Records |
| <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Physician Notes/Records/Orders |
| <input type="checkbox"/> Emergency Department Records | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> History/Physical/Discharge Records | <input type="checkbox"/> Respiratory Therapy Records |
| <input type="checkbox"/> Laboratory Records | <input type="checkbox"/> Social Work Reports/Records |
| <input type="checkbox"/> Nursing Notes/Records | |

for treatment dates of _____.

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:

Julie Hern, RHIT, HIM Director
620-930-3708

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Relationship to Patient

Date

Witness Signature

Date