MEDICINE LODGE MEMORIAL HOSPITAL & PHYSICIANS CLINIC

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

Ashley Taylor, 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:

____ Anesthesia Record
____ Billing Records
____ Consultation Reports/Records
____ Diagnostic Test Reports
____ Emergency Department Records
____ History/Physical/Discharge Records
____ Laboratory Records
____ Nursing Notes/Records
____ Operative Reports/Records
____ Pharmacy Records
____ Physical/Speech/Occupational Therapy Records
____ Physician Notes/Records/Orders
____ Psychotherapy Notes
____ Respiratory Therapy Records
____ Social Work Reports/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

Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.