Kiowa County Memorial Hospital
721 West Kansas Ave.
Greensburg, KS 67054-0616
Telephone (620) 723- 3341 Fax (620) 723-2195

Greensburg Family Practice
721 West Kansas Ave.
Greensburg, KS 67054-0936
Telephone (620) 723-2127 Fax (620) 723-3125

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME: _____
OTHER NAMES USED _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____
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
_____ 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
_____ Other _____

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 re-disclosed 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:

Kiowa County Memorial Hospital
HIPAA Privacy Officer
Greensburg, KS 67054

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____
Personal Representative's Relationship to Patient

_____ _____
Witness Signature Date

Kansas SB119 mandates that all authorizations are no longer valid after one year from the date of signature