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

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: ____[3]

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:

Privacy Officer
400 W. 8th
PO Box 399
Beloit, KS 67420
785-738-2266

____ _______________________________
Signature of Patient or Patient's Personal Representative **Date**

____
Personal Representative's Relationship to Patient

____ _______________________________
Witness Signature

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[3]Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.