

LANE COUNTY HOSPITAL

AUTHORIZATION FOR RELEASE OF HEATH 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:

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

For treatment dates of: _____.

I understand that my health information may contain information related 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 of 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

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:

Lane County Hospital, Privacy Officer
235 West Vine, P.O. Box 969
Dighton, KS 67839
Telephone: (620) 397-5321
Fax: (620) 397-2129

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Relationship to Patient

Date

Witness Signature

Date

Please return form to Lane County Hospital Fax: (620) 397-2129 or Lane County Medical Clinic (620) 397-2264

RESOURCE: MARKETING AUTHORIZATION FORM

ⁱ Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.