240 W 18TH ST. HORTON, KS 66439 785-486-2642 FAX: 7 Corrected Number: 785-486-3620

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	Birth Date:	Social Security No. (optional):

Recipients Name, Address & Contact Information:

_____

_____

_____

_____

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: _____ Event: _____

Purpose of Disclosure:

_____

_____

_____

Description of information to be used or disclosed

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheet		☐ Operative Information ☐ Cath Lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92 ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Signature of Patient/Guardian/Patient/Representative: Date:

_____ _____

Print Name of Patient/Patient's Representative: Relationship to Patient: