

Family Health Center

506 Thorpe, Lakin, Kansas 67860

(620) 355-7550

Authorization Form For Use Or Disclosure Of Protected Health Information At Request Of The Patient

Please Print all information except for required signatures and fill form out **completely**.

Block 1 – Identification of Patient

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____
Street [Apt. number, P.O. Box – as applicable], City, State & Zip Code

SOCIAL SECURITY NUMBER: _____

Block 2 – Type of Records/Information to be Disclosed ---- CHECK ONLY ONE OF THE FOLLOWING BOXES. If neither box is checked or if both boxes are checked, then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPARATE FORMS - One for each purpose.

A. Records except for Psychotherapy ~ Notes B. Psychotherapy Notes only.

PLEASE DESCRIBE WHAT SPECIFIC RECORDS INFORMATION MAY BE USED OR DISCLOSED

(Examples all, X-Rays only, records for last 12 months): _____

- | | |
|---|--|
| <input type="checkbox"/> All | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Alcohol Abuse Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug Abuse Records |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laboratory Reports | |

Block 3 – Name of person or Agency receiving information: _____

Block 4 – Expiration:

This "Authorization" will expire on _____ (MM/DD/YR) or on the following specific event: _____

Block 5 – Purpose for which you wanted records / information used or disclosed: _____

Block 5 – Authorizing Signature

- I understand that if the person or entity that receives the described records / information is not a health care provider or health plan covered by federal privacy regulations, the records / information may be redisclosed and no longer protected by those regulations.
- I may inspect or copy any records information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation to:

Kearny County Hospital
500 Thorpe Street
Lakin, Kansas 67860

Family Health Center
506 Thorpe Street
Lakin, Kansas 67860

- If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

• _____
Signature of Patient or Patient's Personal Representative

Date of Signature

Personal Representative's Relationship to Patient: _____

Printed Name of Personal Representative: _____

