Kearny County Hospital/Family Health Center

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please note: The following form must be completed in its entirety in order to process your request to release your health information.

PRINT PATIENT'S FULL NAME_____

OTHER NAMES USED _____

BIRTHDATE _____ TELEPHONE NUMBER _____

1. Reason for Release: □ At the Request of the Patient □ Other: _____

2. Type of Records/Information to Be Disclosed:

Please describe the records you wish to have released (Examples: All Records, X-Rays Only, Operative Report):

□ All □ History & Physical □ Discharge Summary □ X-Ray Reports □ Laboratory Reports
□ HIV Records □ Alcohol/Substance Abuse Records □ Psychotherapy Notes
□ Other:

_____

_____

3. Please release the medical records described above to (Name/Address of Person/Organization to Receive Your Information):

_____

_____

□ If the recipient I identify in #3 above is a health information organization, exchange, or network, I also authorize this entity to redisclose my information to additional entities as long as the purpose for any such redisclosure is the same as the purpose I describe above.

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. For example, once received by a school district, the records become education records protected by FERPA but are no longer protected by HIPAA

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, condition, or event (not to exceed one year): _____

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made or for the provision of treatment services in reliance on my consent to disclose information to a third party payor. To revoke this authorization, I should contact:

Kimberly Webb
HIPAA Privacy Officer
500 Thorpe Street
Lakin, Kansas 67860
620-355-7111

For Office Use Only
Record Released By:
Date: Time:
Mailed ☐ Scanned ☐
Given to Patient ☐ Faxed ☐

_____ _____

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

_____

Personal Representative's Relationship to Patient*

***If Request is Made by Personal Representative, Please Provide Documentation of Authority to Act on Behalf of Patient.**

Pursuant to KSA § 65-6827 a fee may be charged for copying your medical records.