Kearny County Hospital
Family Health Center

REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

Irma Fonseca	Maranda Martinez	Claria Mendez
HIM Clerk	HIM Clerk	HIPAA Officer

*Please be aware that each time Medical Records are requested a new ROI will need to be filled out for HOSPITAL RECORDS ONLY.

PATIENT HEALTH INFORMATION REQUESED:

Patient name:_____ Address:_____

Telephone: _____-_____-_____ Date of Birth: _____/_____/_____

I, _____, authorize_____ to disclose confidential health information from above-named patient's health information to _____ for the following purpose: _____.

Records Request:

- ☐ Advance Directives
- ☐ Anesthesia Records
- ☐ Clinic Visit Summary
- ☐ Consent for Treatment
- ☐ Detail Bill
- ☐ Diagnostic Study Results (Lab, Radiology, Pathology)
- ☐ Discharge/Narrative summary
- ☐ Emergency Department Record
- ☐ History & Physical Examination Records
- ☐ Medication Records
- ☐ Nursing Notes/Records
- ☐ Operative & Procedure Reports
- ☐ Photographs
- ☐ Physician Notes/Records/Orders
- ☐ Radiology Disc - Request at Radiology
- ☐ Respiratory Therapy Records
- ☐ Therapy/Rehabilitation Records
- ☐ Other:_____

Date(s) of Treatment:_____

Please indicate method of delivery if copies are requested:

- ☐ I will pick up the records from the Hospital.
- ☐ Please fax. My fax number is_____
- ☐ Mail
- ☐ Email to: (must sign consent to email):_____

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CONSENT TO EMAIL: I request Kearny County communicate with me or with another individual about me by email at [email address]. I understand that these communications will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. This information may not be encrypted when sent and may not be completely secured. I understand that the confidentiality of my information may not be completely secured. I understand that electronic communications may be intercepted during transmission, may be misdirected or may be otherwise obtained by third parties. I accept these risks and any possible personal or financial harm which may occur as a result of electronic communications.

I also realize that my email may not actually be received, opened, read or responded to in a timely manner. If I rely upon email, I realize my condition could worsen before I get a response and that I could be harmed as a result of waiting for an email response. I knowingly accept this risk. I realize and hold hospital harmless from any injury I may incur as a result of email communications.

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

_____
Personal Representative's Relationship to Patient

"Kansas SB119 mandates that all authorizations are no longer valid after one year from the date of signature. Pursuant to KSA 65-6827 a fee may be charged by Kearny County Hospital for copying your medical records."

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 re-disclosed 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: _____.

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: **Kearny County Hospital– HIM Department.**

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

_____
Personal Representative's Relationship to Patient

_____ _____
Witness Signature Date