

# 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  
HIM Clerk

Maranda Martinez  
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 REQUESTED:

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:

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

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): \_\_\_\_\_

500 E Thorpe St. Lakin KS 67860 | 620-355-7111 (p) 620-355-8627 (f) or 620-355-8631 (f)

Kearny County Hospital | Family Health Clinic | High Plains Retirement Village

# Kearny County Hospital

## Family Health Center

**CONSENT TO EMAIL:** I request Kearny County communicate with me or with another individual about me by email at: \_\_\_\_\_ . 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

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*"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