Authorization for Release of Health Information

PRINT PATIENT'S FULL NAME_____
OTHER NAMES USED_____
BIRTHDATE_____ SOCIAL SECURITY NUMBER_____
TELEPHONE NUMBER _____

I, _____, authorize **Cheyenne County Hospital/Clinic/County Health** to disclose confidential health information from the above-named patient's health information to [name]_____ for the following purpose:_____.

The information to be disclosed is:

- ☐ Anesthesia Record
- ☐ Billing Records
- ☐ Consultation Reports/Records
- ☐ Diagnostic Test Reports
- ☐ Emergency Department Records
- ☐ History/Physical/Discharge Records
- ☐ Laboratory Records
- ☐ Nursing Notes/Records
- ☐ Operative Reports/Records
- ☐ Pharmacy Records
- ☐ Physical/Speech/Occupational Therapy Records
- ☐ Physician Notes/Records/Orders
- ☐ Psychotherapy Notes
- ☐ Respiratory Therapy Records
- ☐ Social Work Reports/Records

For treatment dates of _____.

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 redisclosed 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:

The Privacy Officer, Shawna Blanka
210 West First Street
St. Francis, KS 67756
785-332-2104

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

_____ _____
Personal Representative's Relationship to Patient **Witness Signature**

****Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.**

Form #66