Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**
Provider's Name:	**Patient M#:**	**Patient F#:**

Provider's Address: Mail to: Attention: HIM Newman Regional Health 1201 W. 12th Ave. Emporia, KS 66801 Fax to: 620.341.7884 Questions Call: 620.343.6800 ext.2625	**Recipient's Name:**		
	Address:		
	City:	**State:**	**Zip:**

This authorization will expire on the following: **Date:** **Event:**

(If I fail to enter a date or event, this authorization will expire in 6 months)

Treatment dates From:_____ **Through:**_____

Purpose of disclosure: _____

Description of information to be used or disclosed

Is this request for psychotherapy notes? ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ❑ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
❑ All PHI in medical record		❑ Discharge Records		❑ Phys Progress Notes	
❑ Anesthesia Record		❑ Laboratory Records		❑ Physician Orders	
❑ Social Work Records		❑ Lab Specimen/Slide		❑ Respiratory Therapy Notes	
❑ Consultation Reports		❑ Nursing Notes/Records		❑ Radiology Films	
❑ Diagnostic Test Reports		❑ Operative Reports		❑ Itemized Bill:	
❑ ER Records		❑ Pharmacy Records		❑ UB−04:	
❑ History & Physical		❑ PT/ST/OT Records		❑ Other:	

I acknowledge, and hereby consent to such, that the released information may contain: ❑ alcohol, ❑ drug abuse, ❑ psychiatric, ❑ HIV testing, ❑ HIV results or ❑ AIDS information. _____ (Initial − if ANY box is checked)

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re−disclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it, if requested.

Section B: The request of PHI is for the purpose of marketing

Will the recipient receive financial or in−kind compensation in exchange for using or disclosing this information? ❑ Yes ❑ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Signature of Patient/Patient Representative **Date**

_____ _____

Print Name of Patient's Representative **Relationship to Patient**

Witness Signature:	**Type of ID:**	**Date Released:**	**Specific Records Released:**
Date Copied:	**# Pages:**	**Copied by:**	**Date Logged:**

Form #1807
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