

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO OTHER ENTITIES**

PRINT PATIENT'S FULL NAME \_\_\_\_\_  
OTHER NAMES USED \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TELEPHONE NUMBER \_\_\_\_\_ M# \_\_\_\_\_ F# \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_, to disclose confidential health information from the above-named patient's health information to:

for treatment dates from: \_\_\_\_\_ through: \_\_\_\_\_

for the following purpose: \_\_\_\_\_.

The information to be disclosed is:

- |   |   |
|---|---|
| <input type="checkbox"/> Anesthesia Record                  | <input type="checkbox"/> Operative Reports/Records                    |
| <input type="checkbox"/> Billing Records                    | <input type="checkbox"/> Pharmacy Records                             |
| <input type="checkbox"/> Consultation Reports/Records       | <input type="checkbox"/> Physical/Speech/Occupational Therapy Records |
| <input type="checkbox"/> Diagnostic Test Reports            | <input type="checkbox"/> Physician Notes/Records/Orders               |
| <input type="checkbox"/> Emergency Department Records       | <input type="checkbox"/> Psychotherapy Notes                          |
| <input type="checkbox"/> History/Physical/Discharge Records | <input type="checkbox"/> Respiratory Therapy Records                  |
| <input type="checkbox"/> Laboratory Records                 | <input type="checkbox"/> Social Work Reports/Records                  |
| <input type="checkbox"/> Laboratory Slides                  | <input type="checkbox"/> Radiology Films                              |
| <input type="checkbox"/> Nursing Notes/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 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: \_\_\_\_\_  
(Authorizations are no longer valid 6 months from the date of signature)

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:

Health Information Management  
1201 W. 12th Ave.  
Emporia, KS 66801  
Phone: 620-343-6800 (x2624)

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative      Date      Relationship

\_\_\_\_\_  
Personal Representative's Address      Telephone Number

\_\_\_\_\_  
Witness Signature      Type of Identification      Date Released

**FOR OFFICE USE ONLY:**

\_\_\_\_\_  
Specific Records Released      # of Pages Released

\_\_\_\_\_  
Date Copied      Copied By (Released By)      Date Logged