AMBERMED – Sheridan County Hospital
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME_____
Other Names Used _____
BIRTH DATE_____ SOCIAL SECURITY NUMBER _____
TELEPHONE NUMBER_____

I, _____authorize
_____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
- ❑ Other

_____

_____

for treatment date(s) 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: _____(3).

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:

Teresa Poage – Privacy Officer
Hoxie Medical Clinic
Hoxie, KS 67740 785-677-4140

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

_____
Personal Representative's Relationship to Patient

_____ _____
Witness Signature **Date**

3Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.