AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I. Individual/Patient (Name and information of person authorizing disclosure):

Printed Name:	Date of Birth:
Street Address:	Area Code and Phone Number:

City:	State:	Zip Code:

II. Authorization and Purpose:

Facility Name: ______________________ may release the specified information to:

Patient/Representative/Hospital/Facility/Physician Name:

Street Address:	Area Code and Phone Number:

City:	State:	Zip Code:

The information will be used/disclosed for the following purpose(s):

- ☐ Continuing Medical Care Use
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Social Security/Disability
- ☐ Military
- ☐ Personal
- ☐ School
- ☐ Other: ______________________

I understand that if the person/entity authorized to receive and use the information is not a health care provider or health plan, the disclosed information may no longer be protected by federal privacy regulations and could be re-disclosed by the recipient.

III. Description of Information to be Used or Disclosed (check all that apply)**:**

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Report
- ☐ Lab/Pathology Report
- ☐ Doctor's Orders
- ☐ Emergency Room Report
- ☐ OP/Procedure Report
- ☐ Face Sheet
- ☐ Medication Report
- ☐ Progress Notes
- ☐ EKG
- ☐ Discharge Instructions
- ☐ Diagnostic Test Results/Reports (X-Ray, CT, MRI)
- ☐ Diagnostic Test Images (CD / Films)
- ☐ Other (Specify: ______________________)

For Dates of Service Starting/Ending: From:______________________To: ______________________

IV. Sensitive Information
I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

V. Expiration and Revocation

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at P.O. Box 1107 Arkansas City, KS 67005. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that time or unless otherwise specified.

VI. Disclosures

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand South Central Kansas Medical Center may not condition my treatment whether I sign this authorization form. I authorize South Central Kansas Medical Center may use and disclose the protected health information as specified above. I further understand I may be charged retrieval/processing fees for copies of my medical records according to Kansas Hospital Licensing law.

VII. Signature

I may receive a copy of this authorization upon signature.

______________________________ ______________________________
Patient's Signature Date Signed

If you are signing as a Power of Attorney, Healthcare Agent, Court-Appointed Guardian, Executor, Administrator or Next of Kin, complete the following and attach a copy of the legal documents as proof of your authority to act on behalf of the patient.

______________________________ ______________________________
Patient Representative's Signature Relationship to Individual

______________________________ ______________________________
Patient Representative's Address City State ZIP

Witness Signature:______________________________ Date: ______________________
To be signed by the Release of Information Associate after proper identification is verified.

Once the authorization form is complete, you can return it to us by using one of the following methods:
Address: 6401 Patterson Pkwy, Arkansas City, Kansas 67005
Fax: 620-441-5982