



312 Custer, Ness City, KS 67560-1654 PHONE:785-798-2291 FAX:785-798-2996

**AUTHORIZATION TO RELEASE HEALTH INFORMATION
PATIENT ACCESS TO HEALTH INFORMATION**

PATIENT'S FULL NAME _____ BIRTHDATE: _____

SOCIAL SECURITY NUMBER _____ TELEPHONE NUMBER _____

I hereby authorize _____ Ness County Hospital, Cedar Village, Ness City Medical Clinic
to disclose confidential health information from the above-named patient's health information to:

Name: _____

Address: _____

Patient requesting access, specify: Inspection Copy

Method of Delivery I will pick records up from hospital.

Please FAX to: _____

Mail

For the following purpose: _____

The information to be disclosed is:

Anesthesia Record

Billing Records

Consultation Reports/Records

Diagnostic Test Reports/Films

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 re-disclosed 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:

Ness County Hospital – HIM Department
312 Custer
Ness City, KS 67560
785-798-2291

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Relationship to Patient

Witness Signature

Date