Ness County Hospital

AUTHORIZATION TO RELEASE HEALTH INFORMATION
PATIENT ACCESS TO HEALTH INFORMATION

PATIENT'S FULL NAME_____ BIRTHDATE:_____

SOCIAL SECURITY NUMBER_____ TELEPHONE NUMBER _____

I hereby authorize _____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**

Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature