CITIZENS MEDICAL CENTER
100 East College Drive
Colby, KS 67701

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT FULL NAME_____
OTHER NAMES USED_____
BIRTHDATE_____ SOCIAL SECURITY NUMBER_____
TELEPHONE NUMBER_____

I, _____, authorize _____
To disclose confidential health information from the above-name 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 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 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:

Privacy Officer
Citizens Medical Center
100 East College Drive
Colby, KS 67701

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

_____
Personal Representative's Relationship to Patient

_____ _____
Witness Signature **Date**

[3]Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.