

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME _____
 OTHER NAMES USED _____
 BIRTHDATE _____ SOCIAL SECURITY NUMBER _____
 ADDRESS _____
 TELEPHONE NUMBER _____

I, _____, authorize McPherson Hospital, Inc. to disclose confidential health information from the above-named patient's health information to _____ for the following purpose: _____.

The information to be disclosed is:

- | | |
|-------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Anesthesia Record | <input type="checkbox"/> Operative Reports/Records |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Pharmacy Records |
| <input type="checkbox"/> Consultation Reports/Records | <input type="checkbox"/> Physical/Speech/Occupational Therapy records |
| <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Physician notes/Records/Orders |
| <input type="checkbox"/> Emergency Department Records | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> History/Physical/Discharge Records | <input type="checkbox"/> Respiratory Therapy Notes |
| <input type="checkbox"/> Laboratory Records | <input type="checkbox"/> Social Work Reports/Records |
| <input type="checkbox"/> Nursing notes/Records | <input type="checkbox"/> Photographs |

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.

I understand that this disclosure will result in some financial gain for the Hospital.

This authorization will expire on the following date or event: 1 Year from signature/Date³

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:

Health Information Management Department
 McPherson Hospital, Inc.
 1000 Hospital Drive
 McPherson, KS 67460

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Address

Personal Representative's Phone Number

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