GREENWOOD COUNTY HOSPITAL
EUREKA, KS

AUTHORIZATIONS FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date: _____ Time: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I hereby consent to disclosure by Greenwood County Hospital to:

Name: _____

Address: _____

Phone Number: _____

Or the hereinafter described confidential information for the following purpose or need:

☐ Continuing Care ☐ Referral ☐ Legal ☐ Disability Determination ☐ At the Request of Patient

☐ Other: _____

The extent or nature of the information to be disclosed is as follows:

☐ Anesthesia Record ☐ Billing Records ☐ Consultation Reports/Records ☐ Emergency Department Records

☐ History/Physical/Discharge Records ☐ Lab Results ☐ Nursing Notes/Records ☐ Operative Reports/Records

☐ Pharmacy Records ☐ Physical/Speech/Occupational Therapy Records ☐ Physician Notes/Records/Orders

☐ Respiratory Therapy Records ☐ Social Work Reports/Records ☐ Complete Medical Record

☐ Other: _____

(indicate EKG, Stress Test, Sleep Study, specific lab or radiology report, etc.)

For Treatment Dates of: _____

This authorization will expire on the following date or event (no more than 1 year): _____

I understand that my medical records (including any information pertaining to mental illness, alcohol or drug abuse) may be protected by Federal and/or State regulations. I also understand that I may revoke this consent, in writing, at any time except to the extent that in any event is consent expires automatically as described above.

I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice similar to the following:

"This information has been disclosed to you from records whose confidentiality is protected by federal (42 C.F.R. Part 2) and/or state laws and you are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for the release of these protected records."

In the event that an oral disclosure is made pursuant to this notice, then said oral disclosure shall be accompanied by or followed by such notice.

I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed 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 have read this consent entitled "Authorization for release of confidential information" and I hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent. I agree that a copy of my signature is as acceptable as the original.

_____ _____

Date Signature of Patient or Patient's Personal Representative

_____ _____

Witness Personal Representative's Relationship to Patient

_____

Witness Printed Name

In the event the patient is a person who has not attained the age of (18) years, then above consent must be executed by said patient's parent, guardian, or other person authorized under Kansas law to act on his or her behalf.