Medical Record Release Authorization

For office use only
Medical Record #_____

DATE _____

ROI# _____

Patient Name_____ Maiden/Previous Name_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/ZIP_____

I.D. _____

I hereby authorize:
(Please choose one or both below)

- ☐ Amberwell Hiawatha:
  Inpatient, Emergency, Surgery, Maternal Care, and outpatient Services
  Phone: 785-742-2131
  Fax: 785-742-6539

- ☐ Clinic Services of Amberwell Health Hiawatha
  (Including Amberwell Hiawatha and associated external clinics)

☐ Copy of records
☐ Access (view) of records

To send/give the following information to:
Name_____

Relationship if other than patient_____

Address_____

City/State/Zip_____

Phone #_____ Fax #_____

For the purpose of:_____

Date Range:_____ **to**_____
☐ Lab/Path Reports_____
☐ Operative/Procedure Reports_____
☐ ER Reports_____
☐ Radiology/CT/MRI Reports_____
☐ Other Hospital Reports_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one or all of you collectively, from any and all illegal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have the right to revoke this authorization. If I want to revoke this authorization before it expires, I may submit a written notice to the Health Information Department at Amberwell Health, 300 Utah Street, Hiawatha , Ks, 66434. I understand that I may not revoke my authorization to the extent it was already acted on and information released prior to my written cancellation was made at my request and with my consent.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative) (Relationship to Patient)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

(OVER)

RESPONSE TO REQUEST FOR ACCESS OF PROTECTED HEALTH INFORMATION

☐ ACCESS GRANTED

AH Employee Signature_____

Released by:

_____ Direct to patient Date:_____

_____ Fax Date:_____

_____ Mailed Date:_____

Request given to copy service on _____(date)

☐ DENIAL OF ACCESS WITH NO RIGHT OF REVIEW

Your request of access to, or a copy of, your protected health information has been denied for the following reason:

_____

There is no right to have this denial of access reviewed.

☐ DENIAL OF ACCESS WITH RIGHT OF REVIEW

Your request of access to, or a copy of, your protected health information has been denied for the following reason:

_____

The denial is subject to review by a healthcare practitioner who did not participate in the original decision. If you would like this decision reviewed, please notify the hospital/clinic, and we will send the records along with the request for the review.

You have a right to file a complaint. You may submit your written complaint to the hospital/clinic by mailing or delivering the complaint to:
Privacy Officer, 800 Raven Hill Drive, Atchison, Kansas 66002
or by mailing the complaint to the Secretary of Health and Human Services at the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201 within 180 days of when you learned, or should have learned, of the act or omission about which you are complaining.

If you file a complaint with the hospital/clinic, we will review the complaint and notify you of the resolution of the complaint. There will be no retaliation for filing a complaint.