AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
AMBERWELL HIAWATHA

PRINT PATIENT FULL NAME ____

BIRTHDATE ______________________________ SOCIAL SECURITY NUMBER ______________________________

TELEPHONE NUMBER ____

I, ____ , authorize (Name) _______________________________________

to disclose confidential health information from the above named patients health information to

____ for the following purpose:

____

Medical Records to obtain (Select One) Kansas state statues allow <u>fees</u> to be applied to requesters. For actual costs, please contact Health Information Management. A quote will be sent to indicate the total cost for the copies that must be paid in full prior to records being released.
☐ Summary of Chart (includes discharge summaries, consultations, emergency room records, outpatient notes, pathology reports, clinic summaries, X-ray (reports only), EKG and Lab reports for the most recent two years) ☐ Records pertaining to (dates or conditions): ________________________ ☐ Other (describe):____ ☐ Entire medical record from date ____/____/____to date ____/____/____

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: ____

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:

Director of Health Information Management
300 Utah
Hiawatha, Kansas 66434
785-742-6255

____ ______________________________
Signature of Patient or Patients Personal Representative Date

____ ______________________________
Personal Representative Relationship to Patient Date

____ ______________________________
Witness Date

People involved in your care:

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Family members that you want Amberwell Hiawatha to communicate with about your treatment:

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Once this document is complete, either fax or mail to:

Amberwell Hiawatha
Attention: Medical Records
300 Utah Street
Hiawatha, KS 66434
Fax:(785)742-6539

Updated 02/01/2022