AUTHORIZATION FOR REALEASE OF HEALTH INFORMATION

Jefferson County Memorial Hospital d.b.a. F.W. Huston Medical Center including all facilities

F.W. HUSTON MEDICAL CENTER

FAX 844.415.1702

Patient Information (Please Print)

First Name: Middle Initial: Last Name:			
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	Soc Sec Num:	
Street Address:	City:	State:	Zip:

Information to be disclosed (Check appropriate boxes below):

___ **ALL RECORDS of the last _____ years** **OR** Date(s) of Service: ____/____/____ through ____/____/____

___ History & Physical ___ Clinician Notes

___ Discharge Summary ___ Emergency Room Records ___ Operative/Procedure Reports ___ Billing Records

___ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

___ Other (Vaccine Records, Medication Lists, etc.) Please specify: _____

I, _____, authorize _____
(patient's name) (provider's name)

at the following fax or address _____
to disclose confidential health information from the above named patient's health information to:

_____ at the following fax or address _____
(Provider's Name)

for the following purpose: _____

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.
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: Medical Records, FW Huston Medical Center, 408 Delaware St, Winchester, KS 66097

X _____ _____ _____
Patient's/ Patient Representative's Signature Relationship to Patient Date

X _____ _____
Witness' Signature Date

*Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.
Revised 1/18

PLEASE FAX ALL RECORDS TO 844.415.1702

408 Delaware St, Winchester, KS 66097 P: 844.536.9449 F: 844.415.1702 www.fwhuston.com