AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ PREVIOUS NAME(S) _____ BIRTHDATE _____ MR# _____
Last Name, First Name, Middle Name

ADDRESS_____CITY_____STATE_____ZIP_____PHONE #_____

I HEREBY AUTHORIZE:

RELEASE OF MEDICAL RECORDS TO:

_____
Name

_____
Street Address

_____
City, State, Zip Code

RELEASE OF MEDICAL RECORDS FROM:

_____
Name

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES: _____

☐ Hospital Inpatient
☐ Hospital Outpatient
☐ Emergency Room
☐ Photographs, videotapes, digital or other images
☐ Abstract Only (Discharge Summary, History & Physical, Operative Report, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports
☐ Other (specify) _____

☐ Bills:
☐ Lab
☐ Radiology Exam (films), Reports
☐ EKG
☐ Immunization Record
☐ Medical Records of other providers in possession of KSB

☐ Office Notes of Dr.(s)
_____
_____
_____

SPECIFIC CONSENT. By checking the boxes below, I am specifically directing whether KSB may use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.

Yes	No		Yes	No	
☐	☐	Records regarding HIV/AIDS Testing/Treatment	☐	☐	Records regarding Mental Health Treatment or Developmental Disability
☐	☐	Records regarding Sexually Transmitted Diseases			
☐	☐	Records regarding Substance Abuse Treatment/Referral (i.e. alcohol or drug)	☐	☐	Psychotherapy Notes (If psychotherapy notes, no other type of protected health information may be listed on this authorization.)
☐	☐	Records regarding Sexual Assault			
☐	☐	Records regarding Child Abuse/Neglect			
☐	☐	Records regarding Genetic Testing			

The foregoing records are to be released for _____.
(state purpose of release)

I understand that I have the right to inspect and receive (upon reasonable notice and for a reasonable fee) a copy of the health information to be disclosed and the right to revoke this authorization at any time prior to the disclosure of this information. Any revocation must be in writing and presented to the Hospital's Health Information Management Services (HIMS) Department. This authorization shall automatically expire (must check one) ☐ on this date_____ or ☐ six (6) months from the date of my signature. Refusal to sign this form will prevent disclosure of information for purposes other than Treatment, Payment or Operations as described in the HIPAA Privacy Rule. There may be circumstances that permit KSB Hospital to charge a reasonable fee for making copies, completing forms, and for postage of all information requested on this authorization. A photocopy of this authorization is considered as valid as the original. (KSB HIMS Dept: 815-285-5925)

Notice to Receiving Agency, Facility or Person:
A patient's medical record is privileged information, which is protected by state and federal laws. Any information disclosed pursuant to the authorization to be subjected to re-disclosure by the recipient is no longer protected by KSB Hospital. Radiographs (x-ray films, MRI films, CT scans) and Pathology slides are a part of the patient's permanent record and are property of KSB Hospital. Loan of the original Radiographs and Pathology slides is made with the express understanding that they are not to be loaned to a third party and shall be returned to KSB Hospital within 30 days. I assume all responsibility in case of loss, theft, or damage of said Radiographs and Pathology slides while on release under my signature.

Patient Signature _____ Date _____ Time _____

Signature of Patient's Legal Representative _____ Date _____ Time _____

Relationship _____

Witness _____ Date _____ Time _____