CLARA BARTON Hospital & Clinics

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient's Full Name _____

Other names used_____

Birthdate_____ Telephone number _____

I, _____, authorize _____

to disclose confidential health information to Clara Barton Hospital & Clinics for the following purpose: _____

_____.

The information to be disclosed is:

- ☐Anesthesia Record
- ☐Billing Records
- ☐Consultation Reports/Records
- ☐Emergency Department Records
- ☐History/Physical/Discharge Records
- ☐Laboratory Records
- ☐Nursing Notes/Records
- ☐Operative Reports/Records
- ☐Pharmacy Records
- ☐Physical/Speech/Occupational Therapy Records
- ☐Physician Notes/Records/Orders
- ☐Psychotherapy Notes (need separate authorization)
- ☐Respiratory Therapy Records
- ☐Social Work Reports/Records

for treatment dates of _____.

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.

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 the Health Information Management Department at Clara Barton Hospital at (620) 653-5092

_____ _____

**Signature of Patient or Patient's Personal Representative** **Date**

_____

**Personal Representative's Relationship to Patient**