ROOKS COUNTY
RCH
HEALTH CENTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME: _____
OTHER NAMES USED: _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
TELEPHONE NUMBER: _____

I, _____, authorize Rooks County Health Center to disclose confidential health information from the above named patient's health information to: _____ for the following purpose: _____

The information to be disclosed is:

Anesthesia Record	Operative Reports/Records
Billing Records	Pharmacy Records
Consultation Reports/Records	Physical/Speech/Occupational Therapy Records
Diagnostic Test Reports	Physician Notes/Records/Orders
Emergency Department Records	Psychotherapy Notes
History/Physical/Discharge Records	Respiratory Therapy Records
Laboratory Records	Social Work Reports/Records
Nursing Notes/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 redisclosed 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:

Jaime Gosselin
Health Information Manager
Rooks County Health Center
P.O. Box 389
Plainville, KS 67663

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

_____
Personal Representative's Relationship to Patient

_____ _____
Signature of Witness **Date**

[3]Kansas SB 119 mandates that all authorizations are no longer valid after one year form the date of signature.