1HROIV

Kansas Heart HOSPITAL

AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

For the following patient:

Patient name | Date of Birth | Social Security #

Release **from**: _____
Name & address of facility/doctor releasing information | Fax # | Phone #

Release **to**: _____
Name & address of facility/doctor/person receiving information | Fax # | Phone #

Information being disclosed for the following purpose:_____

Treatment date(s):_____

Mark the type of information being authorized for disclosure or use. Kansas Heart Hospital (KHH) will not disclose records contained in its medical records prepared by other healthcare providers unless the records are marked and were prepared on behalf of KHH.

___ Patient Demographic Information	___ Nuclear Medicine studies	___ History and Physical
___ Operative/Procedure Report(s)	___ Discharge Summary	___ Billing Records
___ Consultation(s)	___ Progress Notes	___ Invasive Cardiac Studies
___ Imaging/Radiology Reports	___ Lab Tests	___ Other _____

___ Entire Record – will not include billing records unless marked. KHH will not be responsible for completeness or accuracy of records prepared by other healthcare providers on behalf of KHH.

This Consent will remain in effect until_____ or _____
date | occurrence or specified event

at which time this Consent to disclose the identified health information expires. If no date or occurrence given the consent will remain effective for no more than 1 year from the date listed below.

By my initials, I authorize KHH to disclose records containing any of the following information if they are otherwise included within the scope of this authorization. Please initial any or all of the following if applicable:

____ Information relating to diagnosis and treatment to f mental, alcoholic, drug, or emotional condition.
____ Information relating to HIV testing, HIV status, or AIDS
____ Psychotherapy notes

I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. 65-5601 et seq., K.S.A. 59-29b79 and K.S.A. 65-6001 et seq.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that I may refuse to sign this authorization. My treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I understand that if the person or entity that receives the information is not KHH, provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it by sending a written notification by mail or hand-delivering to the following: Privacy Officer or Designee, 3601 North Webb Road, Wichita, KS 67226.

_____ _____/_____
Date | Signature of Patient | Printed Name of Patient

_____/_____/_____
Signature of Authorized Patient Representative | Printed name of Authorized Patient Representative | Description of Representative's Authority

_____/_____
Authorized Representative's Address | Authorized Representative's Phone Number

_____ _____
Date | Signature of Witness

Sent:_____
Faxed:_____
Date:_____
Initials:_____