Authorization to Disclose
Protected Health Information

Osawatomie State Hospital
Osawatomie, KS 66064-0500

Patient Name: _____

Date of Birth: _____

Date(s) of Service:
❑ Current Admission ❑ Date Range: from _____ to:_____

Name:_____Relationship:_____
Address:_____
Phone: _____ Cell:_____ Fax: _____

Purpose of this request:

❑ Discuss the Following:
- ❑History, Treatment Progress, and Discharge Plans
- ❑Other, specify:_____

❑ May Release the Following Available Documents Upon Request of the Above Named Individual or Agency:
- ❑Psychiatric Evaluations ❑Physical Examinations ❑Social Service Assessment Plan
- ❑Discharge Instructions ❑Discharge Summary ❑Laboratory Reports
- ❑Medication Administration Records, specify dates_____
- ❑Progress Notes, specify dates and/or discipline_____
- ❑Other, specify_____

❑ Immediately Obtain the Following Documents from Above Named Individual or Agency, specify:_____
_____
_____
_____

Specify Expiration Date: _____ (If date is not specified, this authorization expires 45 days after discharge. For discharged patients, this authorization expires 90 days after date of signature.)

I authorize disclosure of information specified above that is contained in my medical record to the above named person or agency. I understand that this information includes confidential psychiatric information and may include chemical and/or substance abuse and HIV information which is protected by Federal and State law. I further understand that I may revoke this authorization for disclosure at any time by signing below except to the extent disclosures have already been made. I understand that there may be a charge for documents released.

Signature of Patient or Guardian	Date	Staff Signature	Date	Time
		Witness Signature	Date	Time

(Verbal Authorization requires staff and witness signatures.)

I revoke the above authorization for disclosure, effective: _____ (date).

Signature of Patient or Guardian	Date	Staff Signature	Date	Time
		Witness Signature	Date	Time

(Verbal Authorization requires staff and witness signatures.)