

**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.)