RUSSELL REGIONAL HOSPITAL
200 South Main St. • Russell, KS 67665-2997 • (785) 483-3131

Russell Regional Hospital Physicians Clinic
222 S. Kansas St
Russell, KS 67665
Phone (785) 483-3333

❑ HOSPITAL ❑ CLINIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME_____

OTHER NAMES USED_____

BIRTHDATE_____ SOCIAL SECURITY NUMBER_____

TELEPHONE NUMBER_____

I, _____, authorize _____

to disclose confidential health information from the above-named patient's health information to

[name]_____ for the following

purpose:_____.

The information to be disclosed is:

- ☐ Anesthesia Record
- ☐ Billing Records
- ☐ Consultation Reports/Records
- ☐ Diagnostic Test Reports
- ☐ 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
- ☐ Respiratory Therapy Records
- ☐ Social Work Reports/Records
- ☐ Other_____

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:_____[3]

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:

Russell Regional Hospital
Health Information Management Department

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

_____
Personal Representative's Relationship to Patient

Release of Information Charges: **Effective 1/2/14**

Paper $0.015 X _____ pgs = _____		Discs $ .30 each	X _____ = _____
Labor $4.00 X _____ 15 min = _____		Envelopes $.05 each	X _____ = _____
Postage = _____		10 X 13 manila $.19 each	X _____ = _____
		7.5 X 10.5 manila $0.18 each	X _____ = _____

❑ Patient Received Copies

Total Charges $_____

[3]Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.