

Hutchinson Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Birth Date: _____ Social Security Number _____

Persons/organization providing the information: _____

Persons/organization receiving the information: Dr. Mark Levinson, Hutchinson Hospital, 1701 E. 23rd St, Hutchinson, KS 67502.

Check Type of Information Authorized to be Used And/Or Disclosed

History & Physical Exam	_____	X-Ray Reports	_____
Discharge Summary	_____	Laboratory Reports	_____
Consultative Reports	_____	Progress Notes	_____
Operative Reports	_____	Emergency Room Report	_____
Pathology Reports	_____	Other	_____

Dates of Hospitalization _____ to _____

For the following purpose(s): _____

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires. If this item is left blank, the authorization shall remain effective for 90 days after the date listed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions taken before they received the revocation.

I understand that my medical records (including any psychiatric, alcohol or drug abuse information) are protected by Federal Regulations and cannot be disclosed without written consent unless otherwise provided for in said regulations.

"I understand that my records may contain information regarding the diagnosis or treatment of HIV, (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released."

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

Signature of patient or patient's representative Date

Printed name of patient's representative

Relationship to patient:

Signature of Witness Date