Decatur Health Systems, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Full Name (Print) _____ Date of Birth: _____

Address _____ Phone _____

I hereby authorize _____

To disclose my Health Information to: **Decatur Health Systems, Inc. Family Practice Clinic**

P.O. Box 268, Oberlin, KS 67749 **Phone: (785) 475-2015** **Fax: (785) 475-3847**

Purpose for the disclosure

☐ Treatment/Continued Care ☐ Personal use ☐ Billing or claims ☐ Insurance ☐ School

☐ Legal Purpose ☐ Disability determination ☐ Employment ☐ Other _____

Information to be disclosed

☐ History and Physical Exam	☐ Emergency Room Records	☐ Anesthesia Records
☐ Discharge Summary	☐ Operative Report	☐ PT/OT/Speech Therapy
☐ Progress Notes	☐ Pathology Report	☐ Discharge Instructions
☐ Consultation Reports	☐ EKG/Cardiology Report	☐ Nursing Notes
☐ Lab Reports	☐ Specialty Clinic Records	☐ Respiratory Therapy
☐ Radiology Reports	☐ Clinic Records	☐ Billing Information
☐ Radiology Films	☐ OTHER _____	

Dates of service or time period of records to be disclosed_____

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other condition 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 regulation and may be re-disclosed 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 the form as provided by federal regulation, and that I get a copy of this form after I signed it. This authorization will expire one year form the date signed unless otherwise specified. 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 the Privacy officer at Decatur Health Systems.

_____ _____

Patient Signature of Patient's personal Representative Date

_____ _____

Relationship to Patient (if personal Representative) Witness

☐ Patient Picked up On _____ ☐ Faxed On _____ ☐ Mailed On _____