HIM Department Hours: Monday-Friday 8am-4:30pm

Phone: (316) 358-7850 Fax: (316) 776-5702

Email: HIMStaff@RRHDerby.com

Authorization for Release of Information

Patient's Name:____ Date of Birth:_________________________

1. I authorize Rock Regional Hospital to disclose confidential health information from the above-named patient's health information to:

____ or ☐ Self/Patient

2. Method of Disclosure:

☐ Fax To:____ Attn:____

☐ Mail To:____

☐ Pick-up By: ____Relationship to Patient:___________________

☐ Secure Email:____

3. Description of Health Information to be disclosed:

☐ Records relating to the following treatment, condition, or dates:____

____

☐ Most Recent Visit Physician Notes and Diagnostic Results

☐ Radiology Imaging/Report- Please Specify Dates:____

☐ Laboratory Test Results- Please Specify Dates:____

☐ Other (Please Specify):____

4. The information being requested will be used for the following purpose:

☐ Personal Use

☐ Sharing with healthcare providers as needed

☐ Other (Please Describe): ____

5. I understand that my health information may contain information relating to: HIV, contagious disease, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of such information.

I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations 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 treatment will not be affected by not signing, unless the reason for my treatment includes research or has a prior agreement dependent upon disclosing information.

I understand that I may see and copy the information described on this form as provided by federal regulations, and I have the right to request a copy of this form once it has been completed and signed.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made.

____	__________	____	__________
Signature of Patient or Patient Representative	Date	Witness Signature	Date

Kansas Senate Bill 119 mandates that all authorizations are no longer valid after <u>one year</u> from the date of the signature on this form. Questions regarding the Privacy Practices at RRH can be directed to the Privacy Officer, Nicole Fox, at 316-425-2141 or Privacy@RRHDerby.com