Clay County Medical Center
617 Liberty Street
P.O. Box 512
Clay Center, Kansas 67432

PH: (785) 632-2144
FAX: (785) 632-3686
WEB: www.ccmcks.org

AUTHORIZATION FOR RELEASE OF PATIENT ACCOUNT INFORMATION

Print Patient's Full Name ____ Birthdate_______________

I authorize Clay County Medical Center to disclose confidential health information concerning the patient accounts from the above-named patient's health information to:

____

Address ____ City___________________________

State _______________________ Zip _____________ Fax Number ________________________________

for the following purpose: ____

The information to be disclosed is:

Billing/Account information **For Treatment Dates of _________________________________**

I am aware of the fact that this statement in no way releases me from responsibility of payment to Clay County Medical Center and in no way assigns responsibility to the above named person(s).

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 get a copy of this form after I sign it.

This authorization will expire on the following date or event __________________________________.[4]

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:

Privacy Officer
Clay County Medical Center
Clay Center, Kansas 67432

____ _________________
Signature of Patient or Patient's Personal Representative **Date**

____ _________________
Personal Representative's Relationship to Patient **Date**

____ _________________
Witness Signature **Date**

____ _________________
Witness Signature (if verbal authorization given) **Date**

[4] Kansas Senate Bill 119 mandates that all authorizations are no longer valid after one year from the date of signature

Original to the business office.

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AUTHORIZATION FOR RELEASE OF PATIENT ACCOUNT INFORMATION

Print Patient's Full Name ____(Patient name here)_________________ Birthdate_(Patient date of birth)_

I authorize Clay County Medical Center to disclose confidential health information concerning the patient accounts from the above-named patient's health information to: __________________________________

(company name)____

Address ____(company address)___________________________ City__(company city)______________

State __(company state)________ Zip _(company zip) Fax Number (optional if faxing claim rather than mailing)

for the following purpose: ______(e.g. insurance claim)____

The information to be disclosed is:

Billing/Account information For Treatment Dates of (list dates of service or reference an injury date such as "all dates relating to 11/22/16 injury")

I am aware of the fact that this statement in no way releases me from responsibility of payment to Clay County Medical Center and in no way assigns responsibility to the above named person(s).

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.

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I understand that I may see and copy the information described on this form as provided by federal regulations, and that I get a copy of this form after I sign it.

This authorization will expire on the following date or event (if left blank, defaults to 1 year from signature).[4]

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:

PRIVACY OFFICER
Clay County Medical Center
Clay Center, Kansas 67432

(sign here)____________________________________	(date)_____________
Signature of Patient or Patient's Personal Representative	Date
(complete when representative signs)_____________________	(date as applicable)____
Personal Representative's Relationship to Patient	Date
(witness signature required)___________________________	(date)_____________
Witness Signature	**Date**
(signature when verbal)___________________________	(date as applicable)____
Witness Signature (if verbal authorization given)	**Date**

[4] Kansas Senate Bill 119 mandates that all authorizations are no longer valid after one year from the date of signature