CLAY COUNTY
MEDICAL CENTER
Our Family. Caring for Yours.

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

PH: (785) 632-2144
FAX: (785) 632-2221
WEB: www.ccmcks.org

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Print Patient's Full Name _____ Birthdate_____

I authorize Clay County Medical Center to disclose confidential health information 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: (check appropriate box)

- ☐ Anesthesia Record
- ☐ Billing Records
- ☐ Cardiac Rehab Reports/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
- ☐ Radiology Reports
- ☐ 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 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

_____ _____
Witness Signature **Date**

[4] Kansas Senate Bill 119 mandates that all authorizations are no longer valid after one year from the date of signature