



**HILLSBORO  
COMMUNITY  
MEDICAL CENTER**  
HealthCare for a better tomorrow  
701 South Main  
Hillsboro, KS 67063

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

PRINT PATIENT'S FULL NAME \_\_\_\_\_  
 OTHER NAMES USED \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 TELEPHONE NUMBER (\_\_\_\_) \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_  
 to disclose confidential health information from the above-named patient's health information to  
 name(s) \_\_\_\_\_ for the following  
 purpose: \_\_\_\_\_

The information to be disclosed is:

- |   |   |
|---|---|
| <input type="checkbox"/> Anesthesia Record                  | <input type="checkbox"/> Operative Reports/Records                    |
| <input type="checkbox"/> Billing Records                    | <input type="checkbox"/> Pharmacy Records                             |
| <input type="checkbox"/> Consultation Reports/Records       | <input type="checkbox"/> Physical/Speech/Occupational Therapy Records |
| <input type="checkbox"/> Diagnostic Test Reports            | <input type="checkbox"/> Physician Notes/Records/Orders               |
| <input type="checkbox"/> Emergency Department Records       | <input type="checkbox"/> Psychotherapy Notes                          |
| <input type="checkbox"/> History/Physical/Discharge Records | <input type="checkbox"/> Respiratory Therapy Records                  |
| <input type="checkbox"/> Laboratory Records                 | <input type="checkbox"/> Social Work Reports/Records                  |
| <input type="checkbox"/> Nursing Notes/Records              |   |

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 will get a copy of this form after I sign it.

This authorization will expire on the following date or event: \_\_\_\_\_ <sup>3</sup>

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:

Health Information Director  
 Hillsboro Community Medical Center  
 701 S Main  
 Hillsboro, KS 67063

\_\_\_\_\_  
**Signature of Patient or Patient's Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Personal Representative's Relationship to Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_

<sup>3</sup>Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.