HCHC
HODGEMAN COUNTY HEALTH CENTER
809 WEST BRAMLEY STREET, P.O. BOX 310
JETMORE, KS 67854
PHONE: 620-357-8361
FAX: 620-357-6134
HOSPITAL • RURAL HEALTH CLINIC • INTERMEDIATE SWING BED

PRINT PATIENT'S FULL NAME:_____
OTHER NAMES USED:_____
BIRTHDATE:_____
TELEPHONE NUMBER: _____

I, , authorize to disclose confidential health information from the above-named patient's health information to [name] _____ for the following purpose:

The information to be disclosed is:

- ☐ Anesthesia Record
- ☐ Billing Records
- ☐ Consultation Reports/Records
- ☐ 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 (need separate authorization)
- ☐ Radiology Records
- ☐ Respiratory Therapy Records
- ☐ Social Work Reports/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: _____

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:

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____
Personal Representative's Relationship to Patient