MR# ____________________ .

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of birth:**	**Social Security # (optional)**

Provider Name & Address:	
Allen County Regional Hospital 3066 N. Kentucky, P.O. Box 540 Iola, KS. 66749 HIM Phone: 620-365-1166 FAX: 620-365-1140	**Recipient's Name:** **Address:** **City:** **State:** **Zip:** **Phone #:** **Fax#:**

This authorization will expire on the following Date or Event: OPEN REQUEST (1 Year):

Purpose of disclosure: Further Medical Care ____ Insurance ____ Legal ____ Personal_____ Other____

Description of information to be used or disclosed

Is this request for Psychotherapy notes? ☐if yes, then this is the only item you may request on this authorization. You must submit another authorization for other items listed.
☐if no, you may continue

Description	Date(s)	Description	Date(s)	Description	Date(s)
□ **All PHI in medical record**		□ Physician progress notes		**Radiology:**	
□ ER Report		□ EEG		□ Radiology Report	
□ Labs / Clinical Tests		□ Obstetrical Information		□ CT □ MRI	
□ Medications		□ Senior Life Solutions		□ Mammo	
□ Transfer Forms / EMTALA		**Respiratory:**		□ Ultrasound □ Echo	
□ Operative Info./Path		□ EKG □ Holter Report		□ Image on CD	
□ Therapy -PT / OT / Speech		□ Sleep Study		□ UB-04 □ Itemized bill	
□ History and Physical		□ Pulm Functuntion Test		□ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _________ (Initial) If not applicable, check here. ____

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the "Notice of Privacy Practices."
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may receive a copy of this form after I sign it or a copy may accompany the requested records.

Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing the information? Yes ___ No ____
If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated. If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Signature of Patient /Parent / or Legal Guardian	Date:
PRINT Name of Patient/ Parent / or Legal Guardian:	Relationship to Patient:

# of PGS _____ COST _______ Records Released By:____ Date: _______________