ROI Med Records Request

Allen County Regional Hospital
Iola KS, 66749

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

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

Purpose of disclosure (optional): ☐ 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 Function 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)

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____
  - If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules

Section B: 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 & Time:**
PRINT Name of Patient / Parent / or Legal Guardian:	**Relationship to Patient:**

# of Pages:_____ Cost:_____ Records Released By:_____ Date:_____

Patient Label:

ACR-106 (Rev. 04/29/21)