KIRBY MEDICAL CENTER

Authorization to Release Protected Health Information

Patient Name: ____________________ Date of Birth: __________

Other Names: ____________________ Last 4 digits of SSN: ________ MRN: __________

I authorize: ☐ Kirby Medical Group - Clinic Provider: ____________ ☐ Kirby Medical Center - Hospital

☐ To Release to: ____________________
(Name of Health Care Facility, Individual, or Agency, etc.)

OR

☐ To Request from: ____________________
(Address)

__________ (City, State, Zip) __________ (Phone) __________ (Fax)

Method of Release: ❑ Mail ❑ Pick up at HIM Department (217) 762-1860

❑ Email Email Address: ____________________

SPECIFIC RECORDS TO BE RELEASED:

CLINIC / OTHER	HOSPITAL
Dates: __________ to __________	Dates: __________ to __________
❑ Record Abstract (last 2 years) ❑ Immunization Record ❑ Mental Health (requires additional authorization form) ❑ Other __________ ❑ Complete Record ❑ Billing Records	❑ ED Visit(s) ❑ Operative Report(s) ❑ Billing Records ❑ Immunization Record ❑ Sleep Studies ❑ Laboratory Report(s) ❑ Inpatient Hospitalization ❑ Pathology ❑ Abstract - H&P, Disc Sum, Progress Notes ❑ Radiology ❑ Complete Stay ❑ Reports ❑ Imaging ❑ Complete Record ❑ Therapy Services ❑ Other __________

I specifically authorize the release of information relating to:

❑ **Substance abuse** (including alcohol/drug abuse treatment) ❑ **HIV-related** (HIV/AIDS-related testing) **& communicable disease(s) information**

❑ **Genetic Information** ❑ **Child Abuse/Neglect** ❑ **Abuse of Adult with a Disability** ❑ **Sexual Assault Treatment**

____________________ __________

Patient/Personal Representative Signature **Date**

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The purpose of this disclosure of information is ____
(i.e., continuing care, insurance claim, legal counsel, etc.)

A separate special authorization must be completed to release mental health records.

I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)

I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.

This authorization will expire on the following date or event: ______________________________ If I do not specify an expiration date or event, this authorization will expire in one year.

I understand that I am entitled to a copy of this authorization.

I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

* If the patient is 18 years of age or older, the patient must sign and date the form.

* If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

* If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

☐ Parent ☐ Legal Guardian

______________________________ ______________
Signature **Date**

Printed Name of Person Signing (if not patient): ______________________________ Phone #: ______________

Mailing Address of Patient: ______________________________ City: ______________ State: ________ Zip: ____________

***STAFF USE ONLY** - Released by: Staff Initials: ______________ Type of ID Verified: ______________________ Date: ______________*

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