



HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Print Name of Patient: _____
Patient's Date of Birth: _____ **SSN#** _____ **Phone#:** _____
Patient's Address: _____

I authorize the following: **Rice Community Health, 619 S. Clark Ave, Lyons, KS 67554** to
Disclose/Release my health information, to include:

- | | |
|---|---|
| ☐ Anesthesia Records | ☐ Operative Reports/Records |
| ☐ Billing | ☐ Physical/Speech/Occupational Therapy |
| ☐ Consultation Records | ☐ Physician Notes/Records/Orders |
| ☐ Diagnostic Test Reports | ☐ Psychotherapy Notes (Requires Sensitive Information Selection) |
| ☐ Emergency Department Records | ☐ Respiratory Therapy Records |
| ☐ History & Physical/Discharge Records | ☐ Radiology Reports ☐ Radiology Images |
| ☐ Laboratory Records | ☐ Other: _____ |
| ☐ Nursing Note(s)/Records | _____ |

Disclose/Release records to: _____ **Fax#:** _____ **Ph#:** _____

Date(s) of Service requested: _____ This authorization will expire
on: _____ (if no date entered, expiration date is 1 year from date of request.)

Sensitive Information: This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, reproduction, abortion, or mental health treatment.** Separate consent must be given before this information can be released. **Please select whether you do or do not consent to**

Disclose/Release of this sensitive information:

☐ **I DO NOT** consent to the above information being released ☐ **I DO** consent to the above information being released.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. **HIPAA Privacy Officer, Rice Community Health, 619 S. Clark Ave., Lyons, KS 67554**

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I have a right to receive a copy of this authorization after I have signed it, and this copy is as valid as the original.

Signature of Patient or Authorized Representative: _____

Relationship to Patient: _____ **Date:** _____