

1HROIV



**AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION**

For the following patient:

Patient name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Release from: \_\_\_\_\_  
Name & address of facility/doctor releasing information \_\_\_\_\_ Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Release to: \_\_\_\_\_  
Name & address of facility/doctor/person receiving information \_\_\_\_\_ Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Information being disclosed for the following purpose: \_\_\_\_\_

Treatment date(s): \_\_\_\_\_

Mark the type of information being authorized for disclosure or use. Kansas Heart Hospital (KHH) will not disclose records contained in its medical records prepared by other healthcare providers unless the records are marked and were prepared on behalf of KHH.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Patient Demographic Information  | <input type="checkbox"/> Nuclear Medicine studies | <input type="checkbox"/> History and Physical     |
| <input type="checkbox"/> Operative/Procedure Report(s)  | <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> Billing Records          |
| <input type="checkbox"/> Consultation(s)  | <input type="checkbox"/> Progress Notes           | <input type="checkbox"/> Invasive Cardiac Studies |
| <input type="checkbox"/> Imaging/Radiology Reports  | <input type="checkbox"/> Lab Tests                | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Entire Record – will not include billing records unless marked. KHH will not be responsible for completeness or accuracy of records prepared by other healthcare providers on behalf of KHH. |   |   |

This Consent will remain in effect until \_\_\_\_\_ date \_\_\_\_\_ or \_\_\_\_\_ occurrence or specified event \_\_\_\_\_

at which time this Consent to disclose the identified health information expires. If no date or occurrence given the consent will remain effective for no more than 1 year from the date listed below.

By my initials, I authorize KHH to disclose records containing any of the following information if they are otherwise included within the scope of this authorization. Please initial any or all of the following if applicable:

- Information relating to diagnosis and treatment to f mental, alcoholic, drug, or emotional condition.
- Information relating to HIV testing, HIV status, or AIDS
- Psychotherapy notes

I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. 65-5601 et seq., K.S.A. 59-29b79 and K.S.A. 65-6001 et seq.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that I may refuse to sign this authorization. My treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I understand that if the person or entity that receives the information is not KHH, provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. Kansas Heart Hospital's fee for preparing and sending copies of medical records is \$18.97 plus \$0.63 per page for the first 250 pages and \$0.45 per page for each additional page. The cost for copies of films and records on CD is \$25.00. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it by sending a written notification by mail or hand-delivering to the following: Privacy Officer or Designee, 3601 North Webb Road, Wichita, KS 67226.

\_\_\_\_\_  
Date Signature of Patient / Printed Name of Patient

\_\_\_\_\_  
Signature of Authorized Patient Representative / Printed name of Authorized Patient Representative / Description of Representative's Authority

\_\_\_\_\_  
Authorized Representative's Address / Authorized Representative's Phone Number

\_\_\_\_\_  
Date Signature of Witness Sent: \_\_\_\_\_  
Faxed: \_\_\_\_\_  
Date: \_\_\_\_\_  
Initials: \_\_\_\_\_