MR# _____

□ ***Jimmy Buller, D.O.***
Andrea Willhite, D.O.
Ram Thinakkal, M.D.
400 Katy Ave.
Parsons, KS 67357
Tel. 620-421-2700
Fax 620-421-8135

□ ***Daniel Myers, M.D.***
Kolette Smith, M.D.
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel. 620-421-2733
Fax 620-820-5574

□ ***Demie Ahlquist, P.A.***
324 S. Main
Erie, KS 66733
Tel. 620-244-3291
Fax 620-244-5458

□ ***Mike Carter, P.A.***
200 Carroll
St. Paul, KS 66771
Tel. 620-449-2582
Fax 620-449-2587

□ ***Sonya Culver, D.O.***
Jed Hetlinger, M.D.
Derek Wilson, PA-C
Tel 620-423-3686
2410 Main
Parsons, KS 67357

□ ***Frederick Okie, M.D.***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5145

□ ***Kate Adkins, M.D.***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5571
Fax 620-820-5575

□ ***Beth Shelton, M.D.***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5545
Fax 620-820-5544

□ ***Labette Health Rehab***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5265
Fax 620-820-5140

□ ***Labette Health Cardiac Rehabilitation***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5166
Fax 620-820-5140

□ ***Labette Health Home Care***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-421-0739
Fax 620-820-5479

□ ***Labette Health Wound Care Clinic***
1902 S U.S. Hwy 59
Parsons, KS 67357
Tel 620-820-5514
Fax 620-820-5518

□ ***Labette Health***
1902 S. U.S. Hwy 59
Parsons, Kansas 67357
Health Info Mgmt Dept.
Tel. 620-820-5385
Fax 620-820-5366

_____ _____ _____
(Patient Name) (DOB) (SSN)

_____ _____
(Address) (Telephone)

I hereby authorize **Labette Health** (indicate □ hospital or □ clinic: □to release to □to receive from

_____
(name of agency, program or individual)

_____ Fax # _____
(address)

the items checked below from the medical record of the patient named above:

□ Abstract (past 3 yrs)	□ Physical Progress Notes	□ Stress or Thallium Test
□ Discharge Summary	□ Physician Orders	□ PFT or Sleep Study
□ ER Record	□ Cardiac Labs including:	□ Nursing Documentation
□ History & Physical	CPK, CK or Troponin	□ Imaging/Radiology Reports
□ Consultation	HDL, LDL, Cardiac Enzymes	□ Imaging/Radiology Films
□ Lab Results	Triglycerides, Cholesterol	□ Entire Medical Record
□ Operative/procedure Report	□ 12-lead EKG	□ Other (specify): _____

Specify Dates of Service Requested: _____

Purpose for disclosure: □ Continued Care □ At the request of the patient □ Insurance/Disability □ Litigation □ Other

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. This information will be released unless objection is made by checking the statement below: Do not release my health records pertaining to: □ Sexually transmitted disease □ AIDS □ HIV □ Mental Health Services □ Alcohol and/or drug abuse

I understand that:
1) my records are protected by law and cannot be disclosed without my consent,
2) I am not required to authorize release of confidential information in order to receive services,
3) once the specified information is disclosed as requested, it may be subject to redisclosure,
4) fees may be charged for preparing and sending copies of records as permitted by law,
5) I may inspect or copy the information to be disclosed,
6) I may revoke this consent in writing at any time except for information that has already been released by mailing or hand-delivering written notification to the

Privacy Officer, Labette Health, 1902 S. U.S. Hwy 59, Parsons, KS 67357.

_____ _____ _____ Patient called in request ☐
(Date) Signature of Patient or Representative) (Relationship to patient) Confirmed identity as noted below.

Method of Identification verification?
□ Picture ID □ Signature Comparison □ Known to staff □ Confirmed personal ID i.e. SSN, parent's name, etc.
□ Other (specify) _____ (Attach copies of legal papers as appropriate)

Information □ mailed □ faxed □ given in person #pgs ____ Date Provided _____ By _____

This authorization for the information and dates of service noted above, will remain in effect for one (1) year from the date of signature.