Labette Health
1902 S US Hwy 59
Parsons KS 67357
Health Info. Dept.
Tel 620-820-5385
Fax 620-820-5366

Labette Health Physician Clinics
Parsons – T: 620-820-5800
St. Paul – T: 620-449-2582
Cherryvale – T: 620-336-3255
Independence – T: 620-577-4310

_____ _____ _____
(Patient Name) (DOB) (Acct #)

_____ _____
(Address) (Telephone)

I authorize

Hospital - ☐ Labette Health ☐Home Health ☐Wound Care

Labette Health Physician Clinic – ☐Parsons ☐St. Paul ☐Cherryvale ☐Independence

To disclose my Protected Health Information to:

_____
_____
_____

To receive my Protected Health Information from:

_____
_____
_____

I authorize the disclosure and/or receipt of **the specified Protected Health Information for the time period** listed below (which may include information about mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

I authorize the disclosure and/or receipt of **the specified Protected Health Information for the above time period except as noted below:**

☐Do not disclose mental health records
☐Do not disclose communicable disease records (including HIV and AIDS)
☐Do not disclose other records (identify):_____
☐Do not disclose alcohol/drug abuse treatment records

1. **Dates of Service**: _____

☐ Abstract (past 3 yrs)	☐ Consultation	☐ Physician Progress Notes	☐ Stress or Thallium Test
☐ Discharge Summary	☐ Operative/procedure Rpt	☐ Physician Orders	☐ PFT or Sleep Study
☐ ER Record	☐ Lab Results	☐ Imaging/Radiology CD	☐ Nursing Documentation
☐ History & Physical	☐ 12-lead EKG	☐ Imaging/Radiology Reports	

☐ Other (specify): _____

2. The purpose of this Authorization is: ☐Continued Care ☐Insurance/Disability ☐Litigation/Legal ☐Personal Reasons
☐Other (specify) _____

3. I understand I have the right to revoke this Authorization at any time, except for information that has already been released, by submitting a written request to:

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

4. I understand that my treatment will not be conditioned on whether I sign this Authorization.

5. I understand information disclosed in accordance with this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
(Date) (Patient and/or Representative Signature) Relationship to Patient

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

☐ Picture ID ☐Signature Comparison ☐ Known to staff ☐ Confirmed personal ID i.e.SSN, parent's name, etc.
☐ Other _____

Information: ☐ Emailed ☐ Mailed ☐ Faxed ☐ Given in person #Pgs _____ # CDs_____ Date Provided _____ By_____