1902 S. US Hwy 59, Bldg. E • Parsons, KS 67357
Phone 620-820-5800 • Fax 620-820-5589

PLEASE FAX BACK TO 620-820-5589

Authorization to Release Protected Health Information

____
Patient's Name | Date of Birth | Social Security #

____
Address, City, State, Zip | Telephone # | Medical Record #

I hereby authorize:

____
Organization/Provider Name, Address, City, State, Zip

To ☒ provide to ❑ receive from

Labette Health Physicians Group
____
Provider Name, Address, City, State, Zip

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

- ❑ Abstract Record (last 2 years)
- ❑ Lab Results, dates: ______________________
- ❑ Operative Notes, dates: _________________
- ❑ Progress Notes, dates: ___________________
- ❑ Most Recent H&P
- ❑ Radiology Reports, dates: ________________
- ❑ Path Reports, dates: _____________________
- ❑ Other(specify): ____________________________

Purpose of release: ❑ Continuation of Care ❑ Personal ❑ Transfer of Care ❑ Litigation ❑ Insurance
❑ Other _________________________________

I understand that the following information may be included in my medical record and will be released unless my objection is made by initialing below:

- Substance Abuse (includes tobacco, alcohol, or controlled substance abuse) **initial** ______
- Mental Health (includes headaches, stress, anxiety, depression, etc.) **initial** ______
- Communicable Diseases (includes diagnosis of STD's, HIV/AIDS related testing, treatment, etc.) **initial** ______

This authorization will remain in effect for one year from the date of signature at which time this authorization expires, unless an earlier expiration date is specified at this time. Exp date: _________________

I, the undersigned, understand that my records are protected by law and cannot be disclosed without my consent. I further understand I am not required to authorize this release in order to receive treatment. I understand that once the above named health care organization discloses information as requested by this authorization that the information described above may be subject to re-disclosure. I also understand that fees may be charged for the preparing of and sending the records as permitted by law. I understand that I may inspect or copy the information to be disclosed. I understand I may revoke this authorization at any time (except to the extent that action has already been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: **Attn: Privacy Officer, Labette Health, 1902 S. US Hwy 59, Parsons, KS 67357**

____________________ ____________________________________ ____________________
Date | Signature of Patient (or Patient Representative) | Relationship to Patient

____________________ ____________________________________
Date | Witness Signature (if required)

For Office Use: ❑ **Patient requested that records be copied to electronic media/device.**
Information was:
☐ mailed ☐ faxed ☐ given in person ☐ copied to flash drive, etc. # of pages______ Date provided ____________ By ___________

FORM C-1004