

Labette Health Hospital and Physician Clinics

1902 S US Hwy 59 - Parsons KS 67357

Health Information Management Dept.

Tel 620-820-5385 \* Fax 620-820-5366

Located throughout Southeast Kansas

Parsons Altamont Erie St. Paul

Cherryvale Independence Chanute Oswego

Chetopa Coffeyville

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Patient Name) (DOB) (Acct #)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address/City/State) (Telephone)

**“I authorize”**

*Hospital*: □ Labette Health *Labette Health* □ Parsons □ Altamont □ Erie □ St. Paul

□ Home Health *Physician Clinics*: □ Cherryvale □ Independence □ Chanute □ Oswego

□ Wound Care □ Chetopa □ Coffeyville

To **disclose / receive** my Protected Health Information to/from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the disclosure and/or receipt of **the specified** **Protected Health Information for the dates of service** 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 dates of service listed**

**below except as noted:**

□Do not disclose mental health records □Do not disclose other records (identify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Do not disclose communicable disease records (including HIV and AIDS) □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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Do you want these images ‘password protected’ before we send them to the outside provider indicated above? Yes\_\_\_\_ No\_\_\_\_*

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.

□ Self □ Parent

□ Legal Guardian

□ DPOA

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

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.

(X)\_\_\_\_\_\_\_\_\_\_\_ (X)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(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\_\_\_\_\_\_\_