MCH
MORRIS COUNTY HOSPITAL

600 N. Washington
Council Grove, KS 66846

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www.mrcohosp.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's name_____ **Date of Birth** _____

Social Security# (Last 4 digits):_____ **Phone Number** _____ **Medical Record #:**_____

Address _____

Records To: _____ Phone # _____

Address _____ Fax # _____

Records From:_____ Phone # _____

Address _____ Fax #'s _____

The purpose of this release is to share written and verbal information sufficient to ensure continuity of care. I understand that eligibility, payment or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or 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. 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 (CFR 42).

Purpose for use or disclosure (check one):

- ❑ Continuity of Care
- ❑ Personal
- ❑ Litigation
- ❑ Insurance/Disability
- ❑ Other _____

❑ Medical Record Includes (last 2 years)	❑ Cardiac studies	❑ HIV (Human immunodeficiency virus) results
❑ Emergency Room	❑ Lab Report (s)	❑ Tuberculosis Test Results
❑ History and Physical	❑ Imaging/Radiology Report (s)	❑ Immunization
❑ Consult Report (s)	❑ Rehab Services	❑ Other
❑ Operative Report (s)	❑ Discharge Summary	

Disclosure Format (Paper is default if not marked). ____ **Paper** ____ **CD** _____ **US Mail** _____ **Fax**

Medical Records are being requested for the following dates of treatment:

- ❑ _____ to _____
- ❑ All past, present, and future periods.

The disclosure of all my Protected Health Information for the above time period except as noted below:

- ❑ Do not disclose psychiatric/psychological/mental health treatment records.
- ❑ Do not disclose alchohol/drug abuse treatment records.
- ❑ Do not disclose other records (identify below

_____

This consent shall expire on _____. (If left blank, expiration is 12 months from the date entered below).
I understand that I may revoke this authorization at any time (except to the extent that action has been taken and reliance upon it, by providing verbal or written notice of revocation to MCH Privacy Officer or designated staff.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Signature of Parent or Personal Representative **Relationship to Patient**

Pdrive/HIM Dept/Authorization to Disclose Protected Information

Dept: _____ Completed by: _____ Date: _____