

Greeley County Health Services
Greeley County Hospital
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME _____
BIRTHDATE _____ ADDRESS _____
PHONE NUMBER _____

I AUTHORIZE AND REQUEST GREELEY COUNTY HEALTH SERVICES (GCHS)

HOSPITAL CLINIC
(PLEASE CIRCLE WHERE RECORDS ARE LOCATED)

TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO:

Delivery Method of Records (Circle One): Mail (paper) Mail CD/DVD (digital) Pick-up (paper) Pick-up (digital) Fax (paper)

The information to be disclosed is:

- Billing Records
- Discharge Summary
- Emergency Department Records
- History/Physical/ Records
- Imaging/Radiology Reports
- Laboratory Records
- Nursing Notes/Records
- Operative Reports/Records
- Prescription Records
- Physical/Occupational Therapy Records
- Physician Notes/Records/Orders
- Entire Record (will not include Billing Records or records not prepared by or on behalf of GCHS unless those are also selected)

for the treatment dates of _____

I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it. I understand that I may see and copy the information described on this form as provided by federal regulations, and that I may get a copy of this form if I request after I sign it. I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact: Carol Sherar, PO Box 338, Tribune, KS 67879 Phone: 620-376-4221 Fax: 620-376-2406.

This authorization will expire on the following date or event: _____¹. If item is left blank, the authorization shall remain effective for 60 days after the date listed below beside signature.

I, the undersigned, have read the above and authorize the disclosure of such health information as described. I understand that treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information 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.

CONSENT TO PICK UP BY THIRD PARTY

I authorize Greeley County Health Services (GCHS) to release my records to: _____
I have authorized this individual to pick up a copy of my records from GCHS on my behalf. I understand that these records will contain my protected health information, social information, my personal identification information and may include my date of birth, credit card or banking information. I further understand that GCHS has no control over the records once they are released to this individual. The records could be lost, stolen, viewed by the individual. I accept these risks and any personal or financial harm which may occur as a result of this individual picking up my records.

Signature of Patient or Patient's Personal Representative

Date

Personal Representative's Relationship to Patient

Witness Signature

Date

¹ Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.