

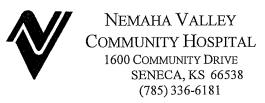


SENECA FAMILY PRACTICE 1600 COMMUNITY DRIVE SENECA, KS 66538 (785) 336-6107

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NA	ME	Sagar	MRN#
BIRTHDATE	SOCIAL SECURITY NUMBER	TELEPHONE	.#
	, author		
to disclose confidential health i	nformation from the above-named patient	's health information to	
[name]		(phone)	
(address)			
for the following purposes:			
**The information to be disclosed *Anesthesia Record *Billing Records *Consultation Reports/Reco *Diagnostic Test Reports *Emergency Department Ref *History/Physical/Discharge *Laboratory Records *Nursing Notes/Records for treatment dates of	ords	*Operative Reports/Records *Pharmacy Records *Physical/Speech/Occupational *Physician Notes/Records/Orde *Psychotherapy Notes *Respiratory Therapy Records *Social Work Reports/Records	
mental health treatment, su authorize disclosure of that be subject to federal privacy	information may contain information bstance abuse treatment, or other coninformation. I understand that once regulations and may be re-disclosed fuse to sign this Authorization and the	nditions which may be specifical my health information has been oby the person receiving it.	lly protected by law and I disclosed, it will no longer
affected if I do not sign the information to another person	nis form unless my treatment include	es research, or the reason for m	by treatment is to disclose
I understand that I may see may request a copy of this f	and copy the information described form after I sign it.	on this form as provided by fed	eral regulations, and that I
This authorization will expi	re on the following date or event:		3
	oke this authorization in writing but the voke this authorization, I should contain		
Signature of Patient or Patie	nt's Personal Representative	Date/Time	
Personal Representative's Ro	elationship to Patient		
			

³Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.





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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

ID VERIFIED BY: Picture ID

Known to Me
Other

Patient's Name:	MRN#		_
Copy Cost Calculations	#	Rate	Total
Charge per Copy (# sheets)		0.03	
Labor (# of 15 increments) 15 mins. minimunn Postage	n	3.90	Mark Co. C.
Total Copying Cost			· ·
Methology for Copy Calculation	A CONTRACTOR OF THE STATE OF TH	(10.41)	
# sheets used	Cos	CATALOGRAPHICATION CONTRACTOR AND A CONTRACTOR	Fpaper & coprer maintenance \$.01, Copier maintenance per sheet \$.01 W copy \$.01
Labor	Ąv	erage HIM (Clerk Wage divided by 4 (15 minute increments)
Postage	Alear cos Sta	se, Memory et per white e ndard mail p	f envelope, postage cost, postage machine Stick cost & CD cost envelope \$.01, cost per manilla envelope \$.10 postage \$.49, Cost per Memory Stick \$10, CD \$10 ne lease \$.03 & postage cost non-standard rate
FOR NVCH/SFP STAFF USE ONLY		-	
RELEASE DATE: BY:			
Pick-up Mail Fax #:			

#890-04

REV: 01-2014