NEMAHA VALLEY
COMMUNITY HOSPITAL
1600 COMMUNITY DRIVE
SENECA, KS 66538
(785) 336-6181

Seneca Family Practice
CLINIC

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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME_____MRN#_____

BIRTHDATE_____ SOCIAL SECURITY NUMBER_____ TELEPHONE # _____

I, _____, authorize _____

to disclose confidential health information from the above-named patient's health information to

[name]_____(phone)_____

(address)_____

for the following purposes: _____.

The information to be disclosed is:

*Anesthesia Record
*Billing Records
*Consultation Reports/Records
*Diagnostic Test Reports
*Emergency Department Records
*History/Physical/Discharge Records
*Laboratory Records
*Nursing Notes/Records
*Operative Reports/Records
*Pharmacy Records
*Physical/Speech/Occupational Therapy Records
*Physician Notes/Records/Orders
*Psychotherapy Notes
*Respiratory Therapy Records
*Social Work Reports/Records

for treatment dates of _____.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be re-disclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I may request a copy of this form after I sign it.

This authorization will expire on the following date or event: _____[3]

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: **MEDICAL RECORDS AT THE ABOVE PHONE NUMBERS**

_____ _____
Signature of Patient or Patient's Personal Representative **Date/Time**

_____
Personal Representative's Relationship to Patient

[3]Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.

#890-04
REV: 01-14

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Patient's Name: _____ MRN# _____

Copy Cost Calculations	#	Rate	Total
Charge per Copy (# sheets)		0.03	_____
Labor (# of 15 increments) 15 mins. minimunm		3.90	_____
Postage			
Total Copying Cost			_____

Methology for Copy Calculation

# sheets used	includes cost of paper & copier maintenance Cost per sheet $.01, Copier maintenance per sheet $.01 & Cost per B/W copy $.01
Labor	Average HIM Clerk Wage divided by 4 (15 minute increments)
Postage	includes cost of envelope, postage cost, postage machine lease, Memory Stick cost & CD cost cost per white envelope $.01, cost per manilla envelope $.10 Standard mail postage $.49, Cost per Memory Stick $10, CD $10 postage machine lease $.03 & postage cost non-standard rate

FOR NVCH/SFP STAFF USE ONLY

RELEASE DATE: _____ BY: _____

Pick-up □ Mail □ Fax #: _____

ID VERIFIED BY: Picture ID □ Known to Me □ Other _____

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