

Patient Name _____ **Medical Record Number/SS No.** _____
Date of Birth _____ **Telephone No.** _____
Address _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

Physician / Clinic / Hospital _____ **Miami County Medical Center**
 Address _____ **2100 Baptiste Drive, P.O. Box 365, Paola, KS 66071**

The type and amount of information to be used or disclosed is as follows:

- ___ All Records.
- ___ 2 years back with most recent test results.
- ___ 5 years back with most recent test results.
- ___ Specific Information: _____

RESTRICTIONS: Only medical records that have originated through this health care facility will be photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the 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 for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

To Release To: _____

Street Address _____

City, State, Zip _____

For the purpose of _____

I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date) (Signature of patient)

(Date) (Signature of authorized representative)

*If signed by a patient's authorized representative:

(Printed name of authorized representative) (Relationship/capacity to patient)

(Address and telephone number of authorized representative)

Original: Medical Records Copy: Patient Copy: Receiving Entity



AUTHORIZATION TO RELEASE INFORMATION

Revised 04/04:HIM-blg **M.C.M.C No. 24.1**