GRISELL MEMORIAL HOSPITAL
210 South Vermont; Ransom, Ks. 67572
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME: _____
OTHER NAMES USED: _____
BIRTHDATE:_____ SOCIAL SECURITY NUMBER: _____
TELEPHONE NUMBER: _____

I, _____, authorize Grisell Memorial Hospital to disclose confidential health information from the above-named patient's health information to _____ for the following purpose:

_____

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 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 redisclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment 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 will get a copy of this form after I sign it.

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

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:

Marie Bernbeck
Privacy Officer
Grisell Memorial Hospital

_____ _____
Signature of patient or Patient's Personal Representative **Date**

_____
Personal Representative's Relationship to Patient

_____ _____
Witness Signature **Date**

Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.