AdventHealth Ottawa

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL/PROTECTED HEALTH INFORMATION

I, _____, born on_____
(patient name) (date of birth)
Patient's address_____

hereby authorize and request_____
Name of Hospital/Provider
To furnish to**: AdventHealth Ottawa, 1301 S. MAIN ST., OTTAWA, KS 66067**

for the purpose of (specify reason for requesting release of information):_____

the following information:
Dictated reports_____ Labs_____ Imaging/X-ray_____(not films) X-ray FILMS_____

Progress Notes_____ Entire Record_____ from(date)_____to(date)_____

Billing/Itemized statements_____Other_____

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

This authorization is valid for the period of 60 days unless a different period is specified, not to exceed 1 year:
_____(alternate period)_____(patient initials)

SIGNATURE of Patient/Patient Representative:_____

DATE SIGNED:_____

Printed Name of Patient/Patient Representative:_____

If patient representative, description of authority to act on behalf of the patient:

_____

Address of Patient Representative:_____

Telephone number of Patient Representative_____

I understand that this authorization may be revoked at any time in writing, except to the extent it has already been acted upon. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by the Federal Privacy Laws. Treatment or payment is not conditioned upon my providing authorization for this use or disclosure. I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand that I may refuse to sign this authorization.
Prohibition on Re-disclosure: This information is released for the above purpose only, and has been disclosed to you from records whose confidentiality is protected by Federal regulations and is not to be re-released without a new authorization/consent by the person (or legal representative) to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose (42 CFR Part 2).

AdventHealth Ottawa 1301 S. Main Street Ottawa, KS 66067 (785) 229-8200