# Reno County Health Department

**209 West 2nd - Hutchinson, KS 67501 - Phone (620) 694-2900 - Fax (620) 694-2905**

## Authorization Form

| Patient's Name | BirthDate | Address |
|---|---|---|
| | | |

CHECK ONE:

☐ I hereby authorize Reno County Health Department to disclose protected health information concerning the above named person to: ____________________

Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made.

Address ____________ Phone # ____________ Fax # ____________

☐ I hereby authorize ____________________ to disclose protected health information concerning the above named person to Reno County Health Department.

Address ____________ Phone # ____________ Fax # ____________

For treatment date(s): ____________________

For the following purpose(s) ____________________

*If the request is initiated by the individual (or his/her representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure. If the purpose relates to marketing, indicate whether Health Department will receive remuneration.*

### Check Type Of Information Authorized To Be Used And/Or Disclosed

Unless the appropriate box is checked, Health Department will ***not*** disclose records contained in its medical records prepared by health care providers not affiliated with Health Department unless the records were prepared on behalf of Health Department

| | | |
|---|---|---|
| ☐ Admission History & Physical | ☐ ID | ☐ Nursing Notes |
| ☐ Alcohol/Drug ________ | ☐ Imaging/Radiology Reports | ☐ Operative/Procedure Reports |
| ☐ Behavior Health ________ | ☐ Immunizations | ☐ Oral Contraceptive Rx |
| ☐ Billing/Payment Records | ☐ Income/Employment | ☐ Pap Smear |
| ☐ Colposcopy Results | ☐ IRIS/Referral | ☐ Physician Findings |
| ☐ Consultation Reports | ☐ Kan Be Healthy Records | ☐ Physician Orders |
| ☐ Discharge Summary | ☐ Insurance | ☐ Physician Progress Notes |
| ☐ ER Records Dated ________ | ☐ Lab Test Results | ☐ Prenatal Records (Current) |
| ☐ Family Planning Records | ☐ MCH Records (Current) | ☐ WIC Records |
| ☐ HIV Records ________ | ☐ Most Recent Exam Findings | ☐ Other |

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal Privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request, a copying charge of up to $0.63 for the first 250 pages and a $0.45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that this authorization expires one year from the date of my signature and I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Health Department's Notice of Privacy Practices by mailing or hand delivering written notification to the following person:

Privacy Officer - Reno County Health Department - 209 West 2nd, Hutchinson, KS 67501

**I authorize the release of my records relating to: (check one)**

________ Treatment rendered prior to the date this authorization is signed.

________ Treatment rendered both before and after the date this authorization is signed.

________ Treatment rendered only after the date this authorization is signed, until further written notice signed.

____________ Date

____________ Signature of Individual/Individual Representative

____________ Printed Name of Representative and Relationship

____________ Representative Address and Telephone Number

____________ Date

____________ Signature of Witness

ORIGINAL - Health Department Records COPY - Individual

**AUTHORIZATION FORM**

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