BLUE RIVER
Family Medicine

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
BLUE RIVER FAMILY MEDICINE

PRINT PATIENT FULL NAME _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

TELEPHONE NUMBER _____

I, _____, authorize _____
to disclose confidential health information from the above named patients health information for the following purpose:
_____

DOCTOR TO RELEASE RECORDS:
Name: _____
Address: _____
Phone: _____

RELEASE RECORDS TO:
Name: BLUE RIVER FAMILY MEDICINE
Address: 1133 COLLEGE AVE, BLDG A STE 213
Phone: 785-587-0570

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
_____ PT/ST/OT Records
_____ Physician Notes/Records/Orders
_____ Psychotherapy Notes
_____ Respiratory Therapy Records
_____ Social Work Reports/Records
_____ X-Ray Reports

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 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 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:

Erin Plummer RN, BSN
1133 College Ave. Bldg A Ste. 213
Manhattan, KS 66502

_____ _____
Signature of Patient or Patients Personal Representative Date

_____
Personal Representative Relationship to Patient

_____ _____
Witness Date