HEALTH RECORDS REQUEST

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Patient Name: _____
*Date of Birth: _____ *Phone: _____
*Address: _____
*City: _____ *State: _____ *Zip: _____

1. ***I authorize the use or disclosure of the above-named individual's health information as described below:***

2. **The following individual or organization is authorized to make the disclosure:**
*Name: _____
*Address: _____
*City: _____ *State: _____ *Zip: _____

3. ***The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).**
   - ☐ Complete health records
   - ☐ Physical exam
   - ☐ Immunization record
   - ☐ Lab results
   - ☐ Radiology reports
   - ☐ Medication List (current)
   - ☐ Other (please specify) _____

4. I understand that the information in my health records 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.

5. **This information may be disclosed to and used by the following individual or organization.**
   *Name: _____
   *Address _____
   *City: _____ *State: _____ *Zip: _____

   For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. 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: _____

7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. 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, payment, or eligibility of benefits. I understand that I may inspect or copy 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 re-disclosure 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 Privacy Officer for the Hutchinson Clinic.

_____ _____
Signature of Patient or **Personal Representative — Date

_____ _____
Printed Name of Personal Representative — Relationship

Please send completed from to Hutchinson Clinic Medical Records by one of the following methods:

Mail	**Fax**	**E-Mail**
2101 N. Waldron Hutchinson, KS 67502	620.669.2501	him@hutchclinic.com

* Required field ** Individual authorized to make health care decisions on behalf of the individual. Must provide proof of relationship.

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written, and informed release of the individual to whom it pertains or as permitted by state law and federal law.