Cotton-O'Neil *Clinic*

Division of Stormont-Vail Health*Care*

Authorization to Disclose/Obtain Health Information

This authorization permits Cotton-O'Neil and/or Pediatric*Care* (Stormont-Vail Health*Care*) to disclose/obtain your health information, including information about medical treatment, substance abuse treatment, mental health treatment and HIV/AIDS status. Please review it carefully.

PATIENT NAME_____ SSN_____ DOB_____

ADDRESS_____ CITY STATE & ZIP_____

PHONE_____ ACCT. NUMBER _____

I authorize the below:

_____
(Name)

_____
(Address)

_____
(City, State, and Zip)

to disclose my health information to:

_____
(Name)

_____
(Address)

_____
(City, State, and Zip)

for the following designated purpose: _____ Treatment _____ Payment _____ Health Care Operations
_____Marketing (I understand that when information is obtained for marketing, there may be financial gain to SVHC).
_____Other (state purpose):_____

Records to be disclosed:

___All Records ___Lab ___ER ___Billing
___Operative ___Anesthesia ___PT/OT/ST ___Immunization Records
___Social Service ___MD Orders/Notes ___Nursing Notes ___History/Physical/Discharge
___All mammography films and related reports ___All breast ultrasound films and related reports
___Original mammography films ___Other_____

The approximate dates of service to be obtained are: _____

I understand that this authorization will expire one year from the date of my signature or upon the following event:

_____

I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.

I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.

I also understand that I may revoke this authorization at any time by delivering a written revocation to the Administrative Offices of Cotton-O'Neil Clinic, 901 Garfield, Topeka, Kansas, 66606.

If I revoke this authorization it will have no effect on actions already taken in reliance on this form.

I understand that Cotton O'Neil Clinic/Pediatric*Care* will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I authorize Cotton-O'Neil Clinic/Pediatric*Care* to obtain/disclose the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit Cotton-O'Neil Clinic/Pediatric*Care* to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

Patient/Personal Representative Signature_____

Relationship of Personal Representative to Patient_____ **Date**_____

Please See Reverse ...

NOTICE

Confidentiality of Alcohol and Drug/Substance Abuse Patient Records

The confidentiality of alcohol and drug/substance abuse records maintained by SVHC is protected by Federal law and regulations. Generally, SVHC may not disclose to a person outside SVHC that a patient is receiving treatment related to alcohol and/or drug/substance abuse, or disclose any information identifying a patient as an alcohol or drug/substance abuser UNLESS:

1. The patient consents in writing,
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the Federal law and regulations of a treatment facility is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the treatment facility or against any person who works for the treatment facility or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

Prohibition on Redisclosure:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Please Read Before Signing Release

Quality Copy Service has contracted with Cotton-O'Neil Clinic to provide you with copies of your medical records.

There is a charge for copying medical records. **If you have any questions or concerns regarding the copy fee, please call (785) 354-0527.**

You will be pre-billed for payment of the copies prior to our releasing them to you. Once payment is received, the records will be released.

All requests for copies of your medical records ***MUST BE IN WRITING***. NO TELEPHONE REQUESTS CAN BE ACCEPTED. To expedite the process, please fill in the information requested on the authorization form completely. Please identify yourself by ***PRINTING*** your name, address, date of birth and phone number. Please be sure to ***SIGN AND DATE*** as we will verify this with your medical record.

Please send your request to:

Cotton-O'Neil Clinic
Attn: Records Release
823 S.W. Mulvane St., LL, Suite A
Topeka, KS 66606

Time Frame

Please allow a minimum of 15 business days for a written request to be processed.

We will mail your records directly to the party requested when payment is received.