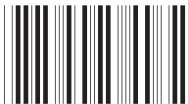
Stormont-Vail
Health*Care*



Authorization to Disclose/Obtain Health Information

This authorization permits Stormont-Vail Health*Care* to disclose or obtain your health information, including information about medical treatment, substance abuse treatment, mental health treatment, & HIV/AIDS status. Please review it carefully.

PATIENT NAME ____ SSN ________________________DOB____________________

ADDRESS ____CITY STATE & ZIP__________________________________

I authorize Stormont-Vail Health*Care* (SVHC) to ❒ **Disclose** my health information to:

-or-

❒ **Obtain** my health information from:

____

(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):____

The records to be disclosed are:

❒ All	❒ Lab	❒ ER
❒ Billing	❒ Operative	❒ Anesthesia
❒ PT/OT/ST	❒ Nursing Notes	❒ Social Service
❒ MD Orders/Notes	❒ Radiology	❒ History/Physical/Discharge

❒ Other: ____

The approximate dates of service to be disclosed 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 Health Information Management Department, 1500 S.W. 10th Ave., Topeka, Kansas, 66604.

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

I understand that Stormont-Vail Health*Care* will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I authorize the disclosure of 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 the disclosure of the records/information upon presentation of a photocopy of this authorization.

Patient/Personal Representative Signature ____

Relationship of Personal Representative to Patient ____ Date ______________________

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.