

Name: _____
DOB: Patient Sticker
MRN: _____



PT MRN _____

Office use only

Authorization to Disclose/Obtain Health Information

This authorization permits Stormont Vail Health and/or Cotton O'Neil Clinics to disclose/obtain your health information. Including information about medical treatment, substance abuse treatment, mental health treatment, and HIV/AIDS status. Please review this authorization carefully. **PLEASE NOTE: A reasonable fee may be assessed for obtaining medical records as allowed by HIPAA.**

PATIENT NAME _____ SSN _____ DOB _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CONTACT PHONE _____ CELL / HOME / WORK _____

Disclosure authorized FROM: (specify Dr. or Location) **Disclosure authorized TO:** (specify Dr. or Location)

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
E-mail _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
E-mail _____

Records to be disclosed:

☐ All Records ☐ Immunizations
☐ History & Physical ☐ Progress Notes
☐ Discharge Summary ☐ Nursing Notes
☐ Operative ☐ Lab/Pathology
☐ MD Consultation ☐ MD Orders
☐ ED Notes ☐ Pharmacy Records

☐ PT/OT/ST
☐ Radiological Reports
☐ Radiological film/imaging
☐ Mammography film/reports
☐ Anesthesia
☐ Verbal Information
☐ Other (specify) _____

For the following designated purpose:

☐ Treatment/Continuation of care
☐ Payment/Insurance
☐ Marketing (I understand there may be financial gain to SVH/COC)
☐ Other (explain) _____

The approximate dates of service to be disclosed

Requested format:

☐ Fax (to Dr. only) ☐ E-mail: by selecting this option, although ☐ Machine Readable Format
☐ MyChart Portal sent using encryption data software, the (for uploading to a separate
☐ Print (select one: mail or hand carry) patient/recipient is aware this method may software system)
☐ CD (select one: mail or hand carry) not be secure on the receiving end, however
they are accepting the risk.

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 re-disclosed 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 (address on second page). 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 or Cotton O'Neil will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. *I authorize Stormont Vail Health/Cotton O'Neil 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 Stormont Vail Health/Cotton O'Neil to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

Patient/Personal Representative Signature _____ Date _____
Relationship of Personal Representative to Patient _____

NOTICE

Confidentiality of Alcohol and Drug/Substance Abuse Patient Records

The confidentiality of alcohol and drug/substance abuse records maintained by SVH and/or COC is protected by Federal law and regulations. Generally, SVH and/or COC may not disclose to a person outside SVH and/or COC 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 Re-disclosure:

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

If you are unable to put your request in writing, please contact the appropriate office listed below for assistance.

Stormont Vail Topeka Campus &
Cotton O'Neil Clinic
Release of Information
1500 SW 10th St.
Topeka, KS 66604
Phone 785-354-6816
(Listen to options and make appropriate selection)

Fax **Clinic** request to: 785-354-4268
Fax **Hospital** request to: 785-354-5119

Office hours 8am-4:30pm, Monday-Friday

Topeka Campus and Cotton O'Neil Clinic email
medicalrecordrequest@stormontvail.org

Stormont Vail Flint Hills Campus
Release of Information
1102 St. Mary's Road, MAB 2
Junction City, KS 66441
Phone 785-579-4433
Fax 785-210-3435

Office hours 8am-4:30pm, Monday-Friday

Flint Hill Campus email
FlintHillsmedicalrecordrequest@stormontvail.org