PT MRN
Patient Sticker

Office use only

Stormont Vail Health

SV1341

Authorization to Disclose/Obtain Health Information

This authorization permits Stormont Vail Health to disclose/obtain your Protected Health Information **(PHI).** 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 Information

Last Name_____ First Name_____ MI_____

Name at Time of Treatment (if different) Last Name_____ First Name_____ MI_____

SSN_____ Birthdate_____/_____/_____ Phone (Cell/Home/Work) _____
Month Day Year

ADDRESS_____CITY_____STATE_____ZIP_____

Provider/Location Authorized to DISCLOSE PHI

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

E-mail_____

Provider/Location Authorized to RECEIVE PHI

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

E-mail _____

Records to be disclosed:

___All Records
___History & Physical
___Discharge Summary
___Operative
___MD Consultation
___Immunizations
___Progress Notes
___Nursing Notes
___ Lab/Pathology
___ MD Orders
___ Pharmacy Records
___PT/OT/ST
___Radiological Reports
___Radiological film/imaging
___Mammogram film/reports
___Anesthesia
___ED Notes
___ Other (specify)
_____
_____
_____
_____
_____

For the following designated purpose:

___Treatment/Continuation of care
___Payment/Insurance
___ Legal
___Other (explain) _____

The approximate dates to be disclosed: ____Past Year ____Past Two Years ____Specific Dates_____
Last two years will be sent unless otherwise specified

Requested format: Records will be released electronically when possible unless otherwise specified below.

___Fax (to healthcare provider only)
___MyChart Portal
___Print (select one: mail or hand carry)
___CD (select one: mail or hand carry)
___E-mail: **by selecting this option, although sent using encryption data software, the patient/recipient is aware this method may not be secure on the receiving end, however they are accepting the risk.**
___Machine Readable Format **(for uploading to a separate software system)**

*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 will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. *I authorize Stormont Vail Health 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 to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

*This authorization will expire one year from the date of my signature or upon the following event: _____

Patient/Personal Representative Signature_____Date_____

Printed Name of signee_____Relationship to Patient_____

Driver's License/Photo ID (Required for pick up) Issuing State _____Number_____

Witness Signature_____Printed_____Date_____

NOTICE

Confidentiality of Alcohol and Drug/Substance Abuse Patient Records

The confidentiality of alcohol and drug/substance abuse records maintained by Stormont Vail Health is protected by Federal law and regulations. Generally, Stormont Vail Health may not disclose to a person outside Stormont Vail Health 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 Health
Release of Information
1500 SW 10th St.
Topeka, KS 66604

Phone 785-354-6816
Fax 785-354-4268

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

Email:
FlintHillsmedicalrecordrequest@stormontvail

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