Authorization for Release of Health Information

Newton Medical Center
600 Medical Center Drive | Newton, KS 67114

ARHI

Please fill out form and fax to HIM at 316-804-6261 with copy of pictured identification

INSTRUCTIONS:

- **Sections 1-5 must be completed. If any section is not complete or section 5 unsigned, this authorization will be considered incomplete and not valid. If you have questions completing this form, please call 316-804-6204.**
- Please print legibly.
- Refer to NMC Notice of Privacy Practices for additional information.

SECTION 1 - Demographic

Print Patient's Full Name:_____ Birth Date:_____

Other Names Used:_____ Social Security Number :_____

Patient Street Address:_____City_____State _____Zip Code_____

Telephone Number: Home_____ Work_____ Fax _____

SECTION 2 – Identification of Party Authorized to Release and Party Authorized to Receive Protected Health Information

Information Requested From: ____Newton Medical Center_____

_____

Release Information To: _____

_____

SECTION 3 –Purpose

Purpose for Release:_____

SECTION 4 – Type of Access Request [ ] Paper Copy of Record [ ] Email [ ] CD [ ] Inspection of Record

Treatment date(s):_____

***Check box A B or C. If you want each type of record/ information disclosed.**

The information to be released is:

[ ] **A. Medical records excluding Psychotherapy notes & Generations records:**

Including:

[ ] Discharge Summary
[ ] Billing Records
[ ] History/Physical
[ ] Radiology/Imaging
[ ] Emergency Department Records
[ ] Consult Reports
[ ] Laboratory Records
[ ] Operative Reports
[ ] Physical/Speech/ Occupational Therapy Records
[ ] Prenatal records
[ ] Other _____

[ ] **B. Clinic Records**

[ ] Advanced Neurology Consultants
[ ] Diabetes & Endocrinology Spec.
[ ] Lovelle Plastic Surgery
[ ] Mid Kansas Family Practice
[ ] Newton Ortho & Sports Med
[ ] Newton Surgical Group
[ ] Medical Plaza of Park City
[ ] Medical Plaza of Valley Center

[ ] **C. Generations records only**

Note: Generations medical record may not be released without prior approval of Generations Medical Director.

Approved:

_____ Initials [ ] **Yes**

[ ] **No**

SECTION 5 –Statements of Understanding

- I understand that once my health information has been released, it will no longer be subject to federal privacy regulations and may be released by the person receiving it.
- I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another person.
- I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.
- Specify the date, event or condition upon which this authorization expires:_____

  (If left blank, expiration date is one year after the day entered below)
- I understand that I can revoke this authorization in writing but that any revocation is not effective for releases that have already been made. To revoke this authorization, I should contact: **Privacy Officer 1-316-804-6026 or Patient Access 1-316-804-6051 or Health Information Mgmt 1-316-804-6204**

Signature of Patient or Patient's Personal Representative:_____ Date: _____

Personal Representative's Relationship to Patient: _____

Printed Name of Personal Representative: _____

Address & telephone number of Personal Representative: _____

TO BE COMPLETED BY HEALTH INFORMATION MANAGEMENT

Approval by Privacy Officer for Non-Treatment Payment Operations requests: Yes____No____Initial_____NA____Date_____

Identification verified by:_____ Date:_____

Information sent by:_____ Number of Copies:_____ Date Copies Sent:_____

MRUN:_____ Date Received in HIM:_____