



Council Grove, KS 66846
600 N Washington
(620) 767-6811
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Authorization Allowing Disclosure to Third Parties

Print Patient Name _____

Patient DOB or SS # _____

I hereby authorize

_____ *[Insert name and address of office/hospital]*

to disclose the following information: _____

_____ *[Identify the protected health information with specific records and dates.]*

to _____

_____ *[Identity of person/entity who is authorized to receive the protected health information.]*

for the following purposes: _____

_____ *[Describe each purpose of the requested use or disclosure.]*

1. This authorization will expire on: _____

_____ *[Date or Event]*

2. I understand I have the right to revoke the authorization by delivering such revocation, in writing, to the disclosing entity, except to the extent it has acted in reliance thereon before notice of such revocation.

3. Except as otherwise provided in this authorization, once the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected by the federal Privacy Rule, 45 C.F.R. parts 160, 162, and 164.

4. The above-named office or hospital may not condition treatment, payment, enrollment, or eligibility for benefits on my providing and signing this authorization for this use or disclosure of my protected health information. However, the above-named office or hospital may condition research related to treatment on the provision of an

authorization for the use or disclosure of protected health information for such research. The above clinic or hospital may condition the provision of health care that is solely for the purpose of creating protected health information for the disclosure to a third party, on provision of an authorization for the disclosure of the protected health information to such third party.

5. I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure of the requested information will result in any remuneration to the above-named office or hospital from a third party, a statement about such remuneration will exist in this authorization.

6. I understand that some information may be subject to special protections pursuant to 45 C.F.R. Part 2; K.S.A. 65-5601 *et seq.*; and K.S.A. 65-6001 *et seq.* **By my initials on the line immediately prior to each of the specifically described records in this paragraph**, I authorize _____ to use or disclose records containing such information if they are otherwise included within the scope of this authorization. As to the records disclosed or used pursuant to my initials in this paragraph 6, I understand that these records shall not be redisclosed without my express written permission. I understand that the records to be used or disclosed pursuant to this authorization **may** contained _____records relating to participation in any federally assisted drug and alcohol abuse programs; _____information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional maintained separately; _____information relating to HIV testing, HIV status, or AIDS

7. I understand that I will receive a copy of this authorization.

Patient Signature

Date

OR

Print Representative's Name

Signature or Personal Representative of Patient

Date

Description of Representative's Authority to Act for Patient

Morris County Hospital

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