

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Rawlins County Health Center

Patient's Legal Name _____ Date of Birth _____

Phone number _____ Email address _____

Obtain Records From (Releasing Facility)		Release Records To (Receiving facility/person)	
Name _____		Name _____	
Address _____		Address _____	
City/State/Zip _____		City/State/Zip _____	
Phone _____	Fax _____	Phone _____	Fax _____

Information to be disclosed for date(s) of service from: _____ through _____

- Hospital Clinic

(Check all that apply)

- | | | |
|---|---|--|
| <input type="radio"/> Anesthesia Record | <input type="radio"/> Emergency Department Records | <input type="radio"/> Mental Health Records |
| <input type="radio"/> Billing Records | <input type="radio"/> History & Physical Exam Reports | <input type="radio"/> Operative/Procedure Reports |
| <input type="radio"/> Clinic/Progress Notes | <input type="radio"/> Immunization Records | <input type="radio"/> Physical/Speech/Occupational |
| <input type="radio"/> Consultation Reports | <input type="radio"/> Laboratory Test Results | <input type="radio"/> Radiology Reports/Images |
| <input type="radio"/> Discharge Summary | <input type="radio"/> Medication/Pharmacy Records | <input type="radio"/> Respiratory Therapy Records |
| <input type="radio"/> Entire Record | | <input type="radio"/> Substance Abuse Disorder Notes |

For the following purpose:

- | | | |
|--|------------------------------------|--------------------------------------|
| <input type="radio"/> Continuation of Care | <input type="radio"/> Personal Use | <input type="radio"/> Claims Payment |
| | <input type="radio"/> Legal | <input type="radio"/> Other _____ |

In the following format: Fees may apply for making paper copies and for mailing.

- | | | |
|-------------------------------------|----------------------------------|--|
| <input type="radio"/> Paper Pick-up | <input type="radio"/> CD US Mail | <input type="radio"/> Email Secure (Encrypted) |
| <input type="radio"/> Paper US Mail | <input type="radio"/> Fax | <input type="radio"/> Email Unsecure (Unencrypted) |
| <input type="radio"/> CD Pick-up | | |

I understand that:

- Requests for copies of medical records and/or non-document materials including postage may be subject to fees.
- Requesting my records to be sent unencrypted to an unsecured email address has risks that include health information that may be intercepted and/or viewed by unauthorized persons. Rawlins County Health Center is not responsible for any risks of sending personal health information through unsecure email.
- My health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law, and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.
- 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 the authorization is to disclose information to another person.
- 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.
- This authorization will expire in one year according to Kansas SB 119 unless specified sooner here: _____.
- I can revoke this authorization in writing by mailing to Rawlins County Health Center, Attn: Medical Records, 707 Grant Street, Atwood, KS 67730. Any revocation is not effective for disclosures that have already been made.

 Signature of Patient or Patient's Personal Representative Relationship Date

 Witness Signature Date

Revised 9/25/2025

Completed by _____