BATES COUNTY MEMORIAL HOSPITAL
615 W. Nursery Street, P.O. Box 370, Butler, MO 64730

AUTHORIZATION TO ACCESS/DISCLOSE HEALTH INFORMATION

Patient Name:____ MR#:____________________________

Date of Birth:____________________________

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

____

Address____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❒ Discharge Summary
- ❒ History and Physical
- ❒ Consultations
- ❒ Laboratory
- ❒ ER Records
- ❒ Other____
- ❒ Radiology Reports/Films
- ❒ EKG's
- ❒ Operative Reports
- ❒ Pathology Reports
- ❒ Entire Record

Dates of Treatment:____

This information may be disclosed to and used by the following individual or organization:

____

Address:____

for the purpose of____

❒ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse (including alcohol or drug screening tests).

❒ I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:____. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days.

❒ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

____ _____________
Signature of Patient or Legal Representative Date

# of pages________

____
If Signed by Legal Representative, Relationship to Patient

____ _____________
Witness Date

Original – Health Information Mgmt Copy – Patient