**William Newton Hospital**
**1300 East Fifth Avenue Winfield, KS 67156 620-221-2300**

# AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Instructions:* All of the Blocks 1 -7 must be completed. If any block is *not* completed then this "Authorization Form" will be considered incomplete and defective and cannot be used.

*PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.*

**Block 1: Identification of Patient**

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____
Street [Apt: number, P.O. box -as applicable], City, State & Zip Code

SOCIAL SECURITY NUMBER or OTHER IDENTIFIER: _____

**Block 2: Type of Records / Information to be Disclosed** -please describe what specific records / information may be used or disclosed. ***Psychotherapy notes may not be included; a separate authorization is required.*** *(Examples: all, X-Rays only, records for last 12 months):*

**Block 3: Persons, facility, or class of persons who are authorized to use or disclose (provide) the records/ information:**

**Block 4: Persons, facility, or class of persons who are authorized to receive the records / information:**

**Block 5: Expiration: This "Authorization" will expire on _____ (MM/DD/YY) or on the following specific event:**

**Block 6: Purpose for which you wanted records / information used or disclosed:**

**Block 7: Authorizing Signature**

- 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 redisclosed and no longer protected by those regulations.
- I understand that the hospital may not condition the provisi9n of treatment or pay[Jlent to an individual by requiring them to complete an authorization
- I may inspect or obtain a copy of any records / information used or disclosed 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 (more information may be found in the Notice of Privacy Practices.).
- If I revoke this authorization it will have no effect on actions already taken on reliance on this form.
- I authorize the use or disclosure of the records/ information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

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

_____ _____
Personal Representative's Relationship to Patient Printed Name of Personal Representative