Norton County Hospital
102 E Holme, Norton, KS 67654
Fax: 785-877-2841

Norton Medical Clinic
807 N State St. Norton, KS 67654
Fax: 785-877-3076

REQUEST FOR USE AND/OR DISCLOSURE OF Protected Health Information Authorization Form

Patient Information:	
Full Legal Name:	DOB:
Phone Number:	Email:

The Information is to be disclosed/released by:	**The Information is to be released/sent to:**
Name:	Name:
Address:	Address:
City & State:	City & State:
Zip:	Zip:
Phone:	Phone:
Fax:	Fax:

I authorize the release of the following records, if such records exist:

	Clinic Notes		**History and Physical**		**Emergency Room Notes**
	Labs, Xrays, EKGs, etc		**Progress Notes**		**Therapy Notes**
	Consultations		**Specialty Clinic Notes**		**Operative/Procedure Notes**
	Discharge Summary		***Treatment Dates:***		

ROUTE OF DELIVERY: **PAPER COPIES** **FAX** _____ **Email** _____

I understand that my health record may contain information related to HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, and 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 disclosed by the person receiving it.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization
- I understand that the Norton County Hospital/Norton Medical Clinic shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the request use of disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this authorization may be revoked in writing and delivered to the Medical Record Department of the Norton County Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed as a result of this authorization could be re-disclosed by the receiver and, if so, may not be subject to federal or state law protecting it's confidentiality.

_____ _____ /_____

Date Signature of individual or representative/Print Name Signed

EXPIRATION DATE:_____ _____ /_____

(This authorization will expire on this date, if no date stated, this authorization is good for six months the date of signature)

Witness Print Name Signed

_____

(Authority of relationship of representative)