

Salina Regional Health Center d/b/a/COMCARE
Authorization For Release Of Health Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Physician/Other: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make the disclosure:
3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)
 - ◇ Entire record
 - ◇ Medication list
 - ◇ List of allergies
 - ◇ Immunization records
 - ◇ Lab results (please describe the dates or types of lab tests you would like disclosed)
 - ◇ X-ray and imaging reports (please describe the dates or types of x-rays or images)
 - ◇ Other (please describe): _____
4. 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.
5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____

Address (City, State, Zip): _____
6. Request records from previous provider:

Name: _____

Address (City, State, Zip) _____
7. This information for which I'm authorizing disclosure will be used for the following purpose:
 - ◇ My personal records
 - ◇ Transfer of Care
 - ◇ Attorney/Court Case
 - ◇ Other: _____
8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

Signature of Witness Date

This Authorization for disclosure of Health Information is effective for one year unless specified and is subject to revocation at any time in writing. Prohibition on re-disclosure — This Information which has been disclosed to you from confidential records may be protected by federal law. Federal regulations (45 CFR 164.508; 42 CFR part 2)
Distribution of Copies: Original to provider, copy to patient, copy to accompany use or disclosure