Stormont Vail Health

Authorization to Disclose/Obtain Health Information

This authorization permits Stormont Vail Health and/or Cotton O'Neil Clinics to disclose/obtain your health information. Including information about medical treatment, substance abuse treatment, mental health treatment, and HIV/AIDS status. Please review this authorization carefully.

PLEASE NOTE: A reasonable fee may be assessed for obtaining medical records as allowed by HIPAA.

PATIENT NAME_____SSN_____DOB_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (Home)_____(Work)_____(Cell)_____

Disclosure authorized FROM:

_____Stormont Vail Health

_____Cotton O'Neil Clinic

_____Specific Physician and/or Provider

_____

_____

Disclosure authorized TO:

Name_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

E-mail_____

Records to be disclosed:

___All Records
___Operative
___Social Services
___ED Notes
___Progress Notes
___PT/OT/ST
___Immunizations
___History/Physical/Discharge
___Lab/Pathology
___MD Orders/Notes
___Nursing Notes
___Other(specify)_____
___Radiological Reports
___Radiological film/imaging
___Mammography film/reports
___Anesthesia
___Verbal Information

For the following designated purpose:

___Treatment/Continuation of care
___Payment/Insurance
___Marketing (I understand there may be financial gain to SVH/COC)
___Other (explain)_____

The approximate dates of service to be disclosed

_____

Requested format:

___Print (via mail)
___CD (via mail)
___MyChart Portal
___Print (hand carry)
___CD (hand carry)
___Fax (to Dr. only)

___E-mail--**by selecting email option, although sent using encryption data software, the patient/recipient is aware this method may not be secure on the receiving end however they are accepting the risk.**

I understand that this authorization will expire one year from the date of my signature or upon the following event:

_____

*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 re-disclosed and no longer protected by those regulations. *I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released 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 (address on second page). If I revoke this authorization, it will have no effect on actions already taken in reliance on this form. *I understand that Stormont Vail Health or Cotton O'Neil will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. *I authorize Stormont Vail Health/Cotton O'Neil to obtain/disclose the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit Stormont Vail Health/Cotton O'Neil to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

Patient/Personal Representative Signature_____

Relationship of Personal Representative to Patient_____**Date**_____

NOTICE

Confidentiality of Alcohol and Drug/Substance Abuse Patient Records

The confidentiality of alcohol and drug/substance abuse records maintained by SVH and/or COC is protected by Federal law and regulations. Generally, SVH and/or COC may not disclose to a person outside SVH and/or COC that a patient is receiving treatment related to alcohol and/or drug/substance abuse, or disclose any information identifying a patient as an alcohol or drug/substance abuser UNLESS:

1. The patient consents in writing,
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the Federal law and regulations of a treatment facility is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the treatment facility or against any person who works for the treatment facility or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

Prohibition on Re-disclosure:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Please Read Before Signing Release

If you are unable to put your request in writing, please contact the appropriate office listed below for assistance.

Please send **Clinic** request to:

Cotton O'Neil
Attn: Records Release
823 S.W. Mulvane St., LL, Suite A
Topeka, KS 66606
Fax: 785-354-4268

Please send **Hospital** request to:

Stormont Vail Health
Release of Information
1500 SW 10th St.
Topeka, KS 66604
Fax: 785-354-5119

Hospital and Clinic requests can be emailed to the following: **medicalrecordrequest@stormontvail.org**