EXCELSIOR SPRINGS HOSPITAL
1700 Rainbow Boulevard
Excelsior Springs, Missouri 64024
816-629-3607 (phone) / **816-629-2704 (fax)**

DATE MAILED ________________ *FAXED* __________

*IMAGES VIA I-CLOUD*_____ *REPORT* _____ *DISC* _______

As set forth more fully in our Notice of Health Information Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. You have a right to review our Notice of Health Information Practices before signing this authorization.

Patient Name ____ **Birth Date** ______________________________

I hereby authorize *EXCELSIOR SPRINGS HOSPITAL* to disclose Protected Health Information (PHI) to:

____
(list where records are to be sent to)

Address: ____________________________________ City: ____________________ State: ________ Zip: ___________

Admission/Discharge Dates: ____
Description of information to be used or disclosed:

____ All Clinical Test Results
____ All Dictated Reports
____ Consultation
____ Discharge Summary
____ Electronic Discharge Instructions
____ Other (Specify):____

___ Electronic Health Information
___ Emergency Room Report
___ History & Physical
___ Laboratory Report (s)

___ Operative Report (s)
___ Pathology Report
___ Pertinent Information
___ Radiology Report(s)

Information that may be released from the medical record may include drug testing, HIV, alcohol and psychiatric information.

This authorization will expire on the following date, event, or condition: ____ (not to exceed 12 months). If I fail to specify an expiration date, event or condition, this authorization will expire 12 months from the date signed.

The purpose of the disclosure: CONTINUATION OF CARE

I understand that this authorization may be revoked at any time except to the extent already acted upon. I understand I may refuse to sign this authorization. Once release of this information is made to the above named person or persons, my information may be subject to re-disclosure by that person or persons. I understand that by signing this document I release and discharge Excelsior Springs Hospital from any liability and will hold Excelsior Springs Hospital harmless for any release made pursuant to this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature: ____ **Date**: ________________

Parent, Guardian, or Authorized Representative Signature: ____Date:_____________________

Witness
Signature____Date______________________

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature Person Completing Request ____ Date______________________

Account # ____ Number of pages _________________