KIT CARSON COUNTY HEALTH SERVICE DISTRICT

AUTHORIZATION FOR INFORMATION RELEASE

I hereby authorize Kit Carson County Memorial Hospital, 286 16th St, Burlington, CO 80807 to release information from the medical records of:

Patient's name: _____

To: _____, Address: _____
or Fax Number: _____

_____ I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychotherapy notes under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.
INITIAL

Identifying Information:

Patient's name at Time of Visit: _____

Healthcare Provider: _____

Date of Birth: _____ Patient and/or Admission Number: _____

Information Requested:

Medical Records from (date) _____ to (date) _____

- Entire medical record including Discharge Summaries, History and Physical, X-ray and Laboratory reports, EKG, EEG, and other documents
- Discharge Summary History and Physical X-ray Laboratory EKG/EEG
- Other: _____ Excluding: _____

Reason for Request: Legal Continued Care Insurance Other_____

Date or event on which this authorization will expire: _____ (Maximum 12 months)

I understand that I have the right to revoke this authorization at any time by making my request in writing to the Kit Carson Community Health Service District Privacy Office at 286 16th St., Burlington, CO 80807. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand there may be a charge for copying and handling my request.

I understand that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that I have the right to inspect or copy the protected health information to be used or disclosed to an entity other than myself.

I understand that I need not sign this form to ensure health care treatment, payment, and enrollment in my health plan or eligibility for benefits.

Patient, Parent or Legal Guardian: _____ Date: _____

Print Name: _____

If signed by other than Patient, indicate relationship: _____

Release by: _____ Date: _____

Effective 04/01/2003

Rev 10/23/2019