Coffeyville Regional Medical Center
www.crmcinc.org

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

-All sections of this authorization form MUST be completed to be considered valid

(Applies to Coffeyville Regional Medical Center and CRMC Medical Associates)

Section A: I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient Last Name: _____First Name: _____MI:_____DOB: _____

Address: _____City: _____State: _____Zip Code: _____

Phone: _____E-Mail Address: (Optional) _____

To / From (circle one)
Coffeyville Regional Medical Center
1400 West Fourth Street
Coffeyville, KS 67337
HIM Dept Ph: 620.252.1152 Fax: 620.252.1504
Requesting CRMC Physician/Department (if applicable):
_____

To / From (circle one)
_____
_____
_____
_____
_____
*Record pick up must have the individual's name listed above

Type of protected health information (PHI) requested:

☐ Surgery ☐ Discharge Summary ☐ Immunizations ☐ Emergency Room ☐ Xray/Imaging Report
☐ Lab ☐ Office Visit Notes ☐ History & Physical ☐ Other: _____
☐ Complete Record (Last two years only unless otherwise specified) (Does not include Billing, Imaging CD/Films, or outside records unless otherwise specified)
Specific Dates: _____to_____ OR: Past Year ☐ Past Two Years ☐

Purpose of Authorization

☐ Continuing Care ☐ Personal ☐ Insurance/Disability ☐ Legal
☐ Other: _____

Authorization expiration date/event/condition: (Not to exceed one year/twelve months) _____

Section B: By signing this authorization form, I understand that:

- **Requests for copies of medical records and/or non-document material may be subject to copying fees.**
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I authorize the release of these records.
- Unless indicated above, this authorization is effective for up to one year/12 month. I understand that I may revoke this authorization at any time in writing except to the extent that action has already been taken in reliance upon it, by giving written notice to the Health Information Department.
- I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by above named facility. The facility, its employees, officers, and attending physicians are released from legal responsibility or liability for release of above information to the extent indicated and authorized herein.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- I understand that authorizing the disclosure of this information is voluntary; I can refuse to sign this authorization. I need not sign this form in order to receive further treatment.
- I have personally received and assume responsibility for any information I have received if transporting to another physician or institution listed above.
- Any disclosure on information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Section C: Signatures and Patient Verification:

Patient/Authorized Representative Signature: _____Date_____Time_____
Printed Name of Authorized Representative: _____
Authorized Representative Relationship to patient: ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other: _____
Patient's Authorized Representative (if applicable):
Address: _____City: _____State: _____Zip Code: _____
Phone: _____
Driver's License or Photo ID (*required when records are picked up)* Driver's License State: _____Number: _____
Printed Name of Witness: _____
Witness Signature: _____Date_____Time_____

OFFICE USE ONLY – Via: ☐ Mailed ☐ Fax ☐ Emailed ☐ Picked up by Patient/Representative ☐ Other
Medical Record #: _____