



***AUTHORIZATION*
FOR SOUTHWEST MEDICAL CENTER
TO RELEASE MEDICAL INFORMATION**

**Telephone: (620) 629-6230
Fax: (620) 629-2427**

PHOTO IDENTIFICATION IS REQUIRED

I, _____ born on _____
Print Patient's Name Month Day Year

Current Address _____
Street City State Zip

Telephone number to contact in regard to this authorization: () _____

Records from Southwest Medical Center Southwest Professional Physicians

I hereby authorize Southwest Medical Center to disclose the following information:
(List specific information to be released including dates)

_____ To: _____
Name
Address
City State Zip

The requested information will be used for _____
i.e., further care, attorney, insurance claim

Southwest Medical Center, its employees and officers, and attending physicians are hereby released of all legal liability that may arise from the release of the above information to the extent indicated and authorized herein. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that my medical records may include information relating to drug and/or alcohol abuse, HIV/AIDS, Sickle Cell Anemia, or mental health conditions and hereby give authorization for release of this information to the party(s) listed above.

I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at Southwest Medical Center. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. All authorizations expire 6 months from the date signed.

I understand that I need not sign this form in order to ensure health care treatment or payment. If I have questions about disclosure of my health information I can contact the Medical Records Department at Southwest Medical Center at the above listed phone or fax numbers. I understand that I will be given a copy of this authorization form, after signing.

Legal Signature of Patient **Date / Time:** _____

OR:

Signature of parent, guardian, or authorized representative **Witness:** _____

Identity confirmed by: Known to staff: _____ Driver's license: _____ SWMC ID Card: _____ Other: _____