HIS Department
P: (620) 629-6230 • F: (620) 629-2427
Southwest
Medical Center
315 W. 15th Street, Liberal, KS
www.swmedcenter.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PHOTO IDENTIFICATION IS REQUIRED

PATIENT NAME_____ **D.O.B.**_____

CURRENT ADDRESS_____ **PHONE #**_____

Records from ☐ Southwest Medical Center ☐ Physician Clinic: _____

I hereby authorize Southwest Medical Center or Southwest Professionals Physicians to use and/or disclose my health information as follows:

DISCLOSE TO:_____
Recipient name Address Phone # Fax #

PURPOSE(S) OF DISCLOSURE:_____
i.e. further care, insurance, attorney, personal records

INFORMATION TO BE DISCLOSED:

☐ History and physical examination	☐ Emergency room record
☐ Progress notes	☐ Discharge summary
☐ Lab reports	☐ Physician orders
☐ X-ray reports	☐ RT reports
☐ Diagnostic Images – CD/films	☐ Consultation Report
☐ Operative report	☐ Other (specify)

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED:_____
(state *specific* time period, "*all*" not acceptable)

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 re-disclosed 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.

_____ _____
Signature of patient or patient's personal representative Date

_____ _____
Relationship to patient if signed by personal representative Witness

Identity confirmed by: Known to staff _____ Driver's license _____ SWMC ID card _____ Other _____ Revised: 4/19

RELEASE