SCHC

SHERIDAN COUNTY HEALTH COMPLEX

PATIENT NAME_____

May Hoxie Medical Clinic and/or members of the office staff release my health information to specified person other than you? ____Yes ____No

If yes, please specify to whom this information may be released:

AUTHORIZED PERSON	Relationship to you	What info may be released to each person? (Please ✔ below)			
		Lab results	X-ray reports	Meds	Medical Status

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination, test results, diagnoses and treatment plans. These are to be used as a basis for planning my care and treatment, and this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that this clinic keeps on premises a copy of the "Notice of Privacy Practices" which provides a more complete description of the uses and disclosures of my medical record and that I have been provided a copy of this document or the opportunity to review this document prior to signing below.

I understand that this document is a part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

_____ _____

Patient or Responsible Party Signature Date

826 18th St. P.O. Box 167 Hoxie, KS 67740 (785) 675-3281 Fax (785) 675-2128