Sherman County Health Department Authorization Form				
Patient's Name		eter e	Birth Date	Address
				ected health information concerning the above person protected health information concerning the above named
Name(s) of person(s)/or	ganization(s) or class(es) of person			sure is to be madeto disclose protected health
information concer	ning the above-named pers	on to She	rman County H	ealth Department.
For treatment date(s):				
If the purpose relates to	d by the individual (or his/her repi marketing, indicate whether Hed CHECK TYPE C	olth Departn of INFORMA	nent will receive re TION AUTHORIZE	TO BE USED AND/OR DISCLOSED
Unless the appropriate box is checked, Health Department will not disclose records contained in its medical records prepared by health care providers not affiliated with Health Department unless the records were prepared on behalf of Health Department).				
Demographic li Payment Recor Lab Test Result Admission Hist Consultation Re Operative/Proc Imaging/Radiol	nformation rds Signary & Physical eports Seedure Reports Sogy Reports	Physician O	iummary tes irds	 □ Entire Record (will not include Billing Records or records not prepared by or on behalf of Sherman County Health Department unless those items also are selected). □ Records not prepared by or on behalf of Sherman County Health Department. Health Department cannot be responsible for the completeness or accuracy of such records.
event) at which time t		ne identifie	d health informa	(occurrence of specified tion expires, but no later than one year from the date listed
I understand that the any federally assisted dependency, or emoti counseling session pro informat pursuant to state and	drug and alcohol abuse progra onal condition, other than not wided such notes are maintain tion relating to HIV testing, HIV	d pursuant m; es recorde ed separat / status, or By my initia	to this authorizat informati d by a mental hea e y (unless this au AIDS. I understa	ays after the date listed below. cion may contain records relating to participation in from relating to diagnosis and treatment of mental, alcoholic, drug alth professional documenting or analyzing conversation during a athorization pertains specifically to psychotherapy notes); and that such information is subject to special protections are use or disclosure of records containing such information if they
I, the undersigned, have treatment is not condi not a health care provi longer protected by the identified below excep of Privacy Practices by	ve read the above and authorize tioned upon the execution of the ider or health plan covered by ose regulations. I understand	te the discludiscless authorical print federal print that I may been takes ten notification.	ization. I underst vacy regulations, revoke this auth n in reliance upor cation to the follo	alth information as described herein. I understand that and that if the person or entity that receives the information is the information described above may be re-disclosed and no orization at any time by providing a written notice to the person it or except as otherwise stated in Health Department's Notice wing person:
Date	Signature of Individual/Individua	l Represento	ntive	
	Printed Name of Representative	and Relation	nship	Representative address and telephone number
Date	Signature of Witness			
		1	herman County Healt 622 Broadway, Good ne (785) 890-4888 F	and KS 67735