ATCHISON HOSPITAL
800 Raven Hill Drive Atchison, Kansas 66002 (913) 367-2131 (913)674-2023 fax **atchisonhospital.org**

Name and addresses of institution/provider releasing records:

_____
_____
_____

I request that my records be released for the purpose of continued treatment. Please send records to the address/fax listed below. If there are any fees associated with this release, I agree to pay those fees.

I understand that these records may include HIV test results, and/or records concerning drug or alcohol abuse treatment and I agree to the release of this information.

Dates of service: _____

The specific nature and extend of the information requested from the medical record is:

_____Discharge Summary	_____History & Physical	_____OT/PT Therapy Evals
_____Physician's Orders	_____Radiology Reports	_____Operation Report
_____Radiology Films	_____Nurse Flow Sheet	_____Social Services
_____Laboratory/Pathology Reports	_____Front Sheet	_____Consultation Reports
_____Cardiopulmonary Assessments	_____Emergency Room Records	_____Progress Notes
_____Psychological Testing/Evaluation	_____Specify Other: _____	

Records are to be forwarded to:

Atchison Hospital
800 Raven Hill Drive
Atchison, Kansas 66002
Phone: 913-360-5507
Fax: 913-674-2011

Unless otherwise stated, this consent to release my records will expire in 30 days from the date of signature.

_____ _____
Patient signature **Date of Birth** Date

_____ _____
Signature of parent/guardian/other Date

_____ _____
Relationship to patient Date

Revised 10/23/17