



KANSAS MEDICAL CENTER (KMC)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (“PHI”)

PATIENT’S NAME:	BIRTH DATE:	ADDRESS:
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CHECK ONE:

- I hereby authorize KMC to use PHI concerning the above-named person.
- I hereby authorize KMC to disclose PHI concerning the above-named person to _____
- I hereby authorize _____ disclose PHI concerning the above-named person to KMC.

COMPLETE THE FOLLOWING:

For treatment date(s) _____

For the following purpose(s): _____
If request is initiated by the individual (or representative), insert “at the request of individual;” otherwise, describe purpose of the use or disclosure.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED:

Unless the appropriate box is checked, KMC will not disclose records contained in its medical records prepared by health care providers not affiliated with KMC unless the records were prepared on behalf of KMC.

- | | | |
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| <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Procedure/Operative Notes | <input type="checkbox"/> Entire Record (will not include Billing Records or records not prepared by or on behalf of KMC unless those items also are selected) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Records not prepared by or on behalf of KMC cannot be responsible for the completeness or accuracy of such records. |
| <input type="checkbox"/> Test Results | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> History and Physical | _____ | |
| <input type="checkbox"/> Discharge Summary | | |

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this time is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain _____ records relating to participation in any federally assisted drug and alcohol abuse program; _____ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); _____ information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, in accordance with the Kansas Dept. of Labor fee schedule. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Privacy Officer, Jerri Ryan, 1124 W. 21st St. N., Andover, KS 67002.

_____ <i>Signature of Individual/Individual Representative</i>	_____ <i>Date</i>	
_____ <i>Printed Name of Representative and Relationship</i>	_____ <i>Representative Phone Number</i>	_____ <i>Representative Address</i>
_____ <i>Signature of Witness</i>	_____ <i>Date</i>	