KANSAS MEDICAL CENTER

KANSAS MEDICAL CENTER (KMC)

Authorization for Disclosure of Protected Health Information ("PHI")

Patient's Name:	Birth Date:	Address:

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

KMC will not disclose records contained in its medical records prepared by healthcare providers not affiliated with KMC unless the records were prepared on behalf of KMC. Records not prepared by or on behalf of KMC cannot be responsible for the completeness or accuracy of such records. Failure to check type of records to release, request cannot be completed.

- ☐ Demographic Information
- ☐ Progress Notes
- ☐ Test Results
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Procedure/Operative Notes
- ☐ Billing Records
- ☐ Other_____
  _____

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 to 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 signature, 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, 1124 W. 21st St., Andover, KS 67002.

_____ _____
Signature of Individual/Individual Representative *Date*

_____ _____ _____
Printed Name of Representative and Relationship *Representative Phone Number* *Representative Address*

_____ _____
Signature of Witness *Date*

KANSAS MEDICAL CENTER

Name_____

Address_____

Phone Number_____

Date_____

Dear Patient:

Thank you for requesting your medical records. **Please allow our Medical Records Department at least 5-7 days to process your request. Records will not be given if not signed by the PATIENT or DPOA. (Appropriate paperwork MUST be presented)**

Please indicate below where you would like your Medical Records sent after processed:

- Faxed - *please list Name and Number*_____
- Mailed - *please list Name and Address* _____
- Pick Up **- Please note – per law, it must be the patient or the DPOA (with appropriate paperwork present) to pick up the records.** *A member of our Medical Records team will call you when records have been processed and are ready for you to pick up*

I have an appointment scheduled on _____ with Dr._____ .

Thank you for your cooperation.

Sincerely,

[Your signature]_____

[Your name printed]_____

NOTE: ***HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason****.*