## Hays Medical Center Authorization Form

PATIENTS NAME	BIRTH DATE	Address			
I HEREBY AUTHORIZE AND REQUEST HAYS MEDICAL CENTER (PLEASE INDICATE WHERE RECORDS LOCATED)  □ HOSPITAL □ CLINIC NAME					
TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO:					
Name(s) and address(s) of person(s)/organization(s) or class (es) of persons/organizations to which disclosure is to be made.					
For treatment date(s):					
For the following purpose(s):					
If the request is initiated by the individual (or his/her 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, Hays Medical Center will <i>not</i> disclose records contained in its medical records prepared by health care providers not affiliated with Hays Medical Center unless the records were prepared on behalf of Hays Medical Center.					
<b>Demographic Information</b> □ Hospital □ Clinic	Cardiac/Imaging Rep  □ Hospital □ Clir		☐ Entire Record (will not include Billing Records or records not prepared by or on		
Emergency Room Records	Physician Progress N		behalf of Hays Medical Center unless those		
☐ Hospital ☐ Clinic  Admission History & Physical	☐ Hospital ☐ Clir Physician Orders	nic	items also are selected).		
□ Hospital □ Clinic	□ Hospital □ Clir	nic	□ Records not prepared by or on behalf of Hays Medical Center. Hays Medical		
Consultation Reports  ☐ Hospital ☐ Clinic	Discharge Summary  □ Hospital □ Clir	nic	Center cannot be responsible for the		
Operative/Procedure Reports	Nursing Notes	mia	completeness or accuracy of such records.		
☐ Hospital ☐ Clinic  Lab Test Results	☐ Hospital ☐ Clir Billing Records	.IIC	□ Other		
□ Hospital □ Clinic	☐ Hospital ☐ Clir				
Imaging/Radiology Reports  □ Hospital □ Clinic	Oncology Treatment  □ Hospital □ Clir				
□ PT/OT/ST/AT notes □ Prescription Records					
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, <b>but no later than one year</b>					
from the date listed below. If this item 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 <b>drug and alcohol abuse program</b> ; information relating to diagnosis and treatment <b>of mental, alcoholic, drug dependency, or emotional condition</b> , 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 <b>HIV testing, HIV status or AIDS.</b>					
Initial here if you do not wish this information to be disclosed.					
I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. 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, including a charge for labor and supplies, and the reasonable cost of all duplications of records that cannot be					
routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time except to the					
extent that action has been taken in reliance upon it or except as otherwise stated in Hays Medical Center's Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Privacy Officer, Hays Medical Center, 2220					
Canterbury Drive, P.O. Box 8100, Hays, Kansas 67601.					
Date/Time Signature of Individual/Individual Representative					
Printed Name of Representative and Relationship  Representative address and telephone number					
Date/Time Signature	of Witness OR	RIGINAL – H	GINAL – Hays Medical Center COPY – Individual		
THAYSMED					
HAYS, KANSAS					