# SALINA REGIONAL HEALTH CENTER
## AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

| PATIENT NAME | BIRTH DATE | SOCIAL SECURITY NO. |
|---|---|---|
| Patient Address | | Patient telephone |

**CHECK ONE:**

☐ I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE NAMED PATIENT

☐ I HEREBY AUTHORIZE_____TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:_____

*Name(s) of person(s) organization(s) and address(es) of persons/organizations to which disclosure is to be made*

For Treatment date(s):_____

***Specify date(s)- this line MUST BE completed***

For the following purposes(s) _____

***If the request is initiated by the patient (or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Provider will receive remuneration.***

**CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED**
**(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected) | ☐ | Patient Demographic Information | ☐ | Cardiac Studies |
| | | ☐ | Emergency Room Records | ☐ | Physician Progress Notes |
| ☐ | Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records. | ☐ | Admission History & Physical | ☐ | Physician Orders |
| | | ☐ | Consultation Reports | ☐ | Discharge Summary |
| | | ☐ | Operative/Procedure Reports | ☐ | Nursing Notes |
| ☐ | Other_____ | ☐ | Lab Test Results | ☐ | Billing Records |
| | | ☐ | Imaging/Radiology Reports | **DATE INFORMATION IS NEEDED:** | |

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. If this item is left blank, the authorization shall remain effective for one year from the date of signature.

I understand that the records to be used or disclosed pursuant to this authorization may contain information that is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S. A. § 65-6001et seq. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

☐ 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
☐ Information relating to HIV testing, HIV status, or AIDS

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 as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to: Health Information Management, Privacy Office, 400 S. Santa Fe, Salina, KS 67401. Phone (785) 452-7313 Fax (785) 452-7312 (Note: Revocation is not effective for disclosures that have already been made)

_____ _____
*Date* *Signature of Patient or Authorized Agent/Representative*

_____ _____
*Printed Name of Authorized Agent/Representative* *Authorized Agent/Representative's Relationship to Patient*

_____ _____
*Address of Authorized Agent/Representative* *Telephone # of Authoized Agent/Representative*

_____ _____
*Date* *Signature of Witness*

**ORIGINAL –Patient Medical Record** **COPY – Patient (if signed in presence of SRHC staff)**