

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (PHI)**

**Health Information Department at (316) 268-8134**

**Instructions:**

- Please complete the form in full. If any section is incomplete, this authorization will be considered incomplete and invalid.
- Please print legibly. Use blue or black ink only and do not use a pencil.

**SECTION 1- Demographic**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name at time of treatment (if different): \_\_\_\_\_

Patient Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number – Home: \_\_\_\_\_ Work: \_\_\_\_\_

Fax: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ eMail: \_\_\_\_\_

**SECTION 2- Identification of Entity/Persons/Class of Persons authorized to receive PHI**

**Release Information From:**

Via Christi Hospital on St. Francis  E. Harry  St. Teresa  Behavioral Health Center

Attention: \_\_\_\_\_

Other (Specify Facility & Address below, including phone/fax if known)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Release Information To:**

Via Christi Hospital on St. Francis  E. Harry  St. Teresa  Behavioral Health Center

Attention: \_\_\_\_\_

Other (Specify Facility & Address below, including phone/fax if known)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 3- Type of access requested** \_\_\_\_\_ Copies of Record \_\_\_\_\_ Inspection of Record \_\_\_\_\_ Verbal Disclosure \_\_\_\_\_ Electronic

Treatment date(s): \_\_\_\_\_

Please describe the specific PHI you are requesting (check all that apply):

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Emergency Room      | <input type="checkbox"/> Cardiac Studies             | <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical  | <input type="checkbox"/> Lab report(s)               | <input type="checkbox"/> Pathology Report(s) | _____                                 |
| <input type="checkbox"/> Consult Report(s)   | <input type="checkbox"/> Imaging/Radiology Report(s) | <input type="checkbox"/> Entire Record       | _____                                 |
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Rehab Services              |  |                                       |

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

**SECTION 4- Expiration**

Unless otherwise revoked, this Authorization shall expire upon this date: \_\_\_\_\_ or no later than one year from the date of this Authorization.

**SECTION 5- Purpose**

Purpose for use or disclosure (check one):

- Continued care  Insurance/Disability  Litigation  Personal  
 Other: \_\_\_\_\_

**SECTION 6- Statements of Understanding**

- I understand that this authorization is voluntary and that I may refuse to sign it.
- If I do not sign this form, my health care or payment for health care will not be affected.
- I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.
- I understand that I may revoke this Authorization at any time by delivering a written revocation to the Health Information Management Department at 929 N. St. Francis, Wichita, KS 67214.
- I understand that if I revoke this authorization, it will have no effect on disclosures already made in reliance on this Authorization
- I authorize the use or disclosure of the Protected Health Information, as described. I have received a copy of this form.

Signature of patient/legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of representative: \_\_\_\_\_ Representative's authority to act: \_\_\_\_\_

(Must attach copy of legal documents validating authority)

**Please select the correct location where you were treated and fax or mail this authorization to:**

Via Christi Hospital  
St. Francis  
929 N. St. Francis  
Wichita, KS 67214  
Fax: 316.268.8697

Via Christi Hospital  
E. Harry  
3600 E. Harry  
Wichita, KS 67218  
Fax: 316.689.5387

Via Christi Behavioral Health Center  
(Submit to E. Harry location)

Via Christi Hospital on St Teresa  
14800 W. St. Teresa  
Wichita, KS 67235  
Fax: 316.268.8697

