McPherson HOSPITAL

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

McPherson Hospital – 1000 Hospital Drive – McPherson KS 67460
Phone (620) 240-2250 ext. 475 -- FAX (620) 798-2631

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: _____

SECTION 2- Type of access requested

_____ Paper Copy of Record _____Electronic Copy of Record _____ Inspection of Record

Treatment date(s): _____

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

☐Abstract	☐Consult Report(s)	☐Physicians' Orders	☐Pathology Report(s)
☐Face Sheet	☐Operative Report(s)	☐Rehab Services	☐Entire Record
☐Emergency Room	☐Cardiac Studies	☐Medication Record	☐Other:
☐History & Physical	☐Lab report(s)	☐Nursing Notes	_____
☐Progress Notes	☐Imaging/Radiology Report(s)	☐Discharge Summary	_____

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 3- Identification of Entity/Persons/Class of Persons authorized to receive or release PHI

Release Information From:	***Release Information To:***
Name/Facility **McPherson Hospital**	Provider/Facility Name _____
Address **1000 Hospital Drive**	Address _____
City/State/Zip **McPherson KS 67460**	City/State/Zip _____
Phone **620-240-2250 Ext. 475**	Phone _____
For continuing care, Fax # **620-798-2631**	

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 ☐ Litigation ☐ Other: _____

☐ Insurance/Disability ☐ Personal _____

SECTION 6- Statements of Understanding

- I understand that this authorization is voluntary and that I may refuse to sign it.
- I understand that I may refuse to sign this Authorization. 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 1000 Hospital Drive, McPherson KS 67460.
- 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)

*Notified patient of a possible charge: