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 *not* 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.

Demographic Information
□ Hospital □ Clinic

Emergency Room Records
□ Hospital □ Clinic

Admission History & Physical
□ Hospital □ Clinic

Consultation Reports
□ Hospital □ Clinic

Operative/Procedure Reports
□ Hospital □ Clinic

Lab Test Results
□ Hospital □ Clinic

Imaging/Radiology Reports
□ Hospital □ Clinic

□ **PT/OT/ST/AT notes**

Cardiac/Imaging Reports
□ Hospital □ Clinic

Physician Progress Notes
□ Hospital □ Clinic

Physician Orders
□ Hospital □ Clinic

Discharge Summary
□ Hospital □ Clinic

Nursing Notes
□ Hospital □ Clinic

Billing Records
□ Hospital □ Clinic

Oncology Treatment Records
□ Hospital □ Clinic

□ **Prescription Records**

□ **Entire Record (will not include Billing Records or records not prepared by or on behalf of Hays Medical Center unless those items also are selected).**

□ **Records not prepared by or on behalf of Hays Medical Center. Hays Medical Center cannot be responsible for the completeness or accuracy of such 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 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 **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 or 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.**

_____ **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 *Signature of Individual/Individual Representative*

_____ _____

Printed Name of Representative and Relationship *Representative address and telephone number*

_____ _____

Date *Signature of Witness*

ORIGINAL - Hays Center. Medical COPY - Individual

HaysMedicalCenter
HAYS, KANSAS

DOB: A/Sdt: -

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