AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
Health Information Department at (785) 565−4737

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, ST, Zip , _____

Telephone Number − Home: _____ Work: _____

Fax: _____ Social Security Number: _____ e−mail: _____

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

Release Information **From Via Christi:**
❑ Manhattan

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

_____
_____
_____

Release Information **To Via Christi:**
❑ Manhattan

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):

❑ Emergency Room ❑ Cardiac Studies ❑ Discharge Summary ❑ Other: _____
❑ History & Physical ❑ Lab report(s) ❑ Pathology Reports _____
❑ Consult Report(s) ❑ Imaging/Radiology Report(s) ❑ Entire Record
❑ Operative Report(s) ❑ 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 signe this form, my health care or payment for health care will not be affected.
- I understand that one the disclosures authorized herein have been make, 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 be delivering a written revocation to the Health Information Management Department at 1823 College Ave, Manhattan, KS 66502
- 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 Manhattan
1823 College Ave.
Manhattan, KS 66502
Fax: 785.776.2231