

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, 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:

St. Francis St. Joseph St. Teresa Behavioral Health Center
 Rehab Hospital

Attention: _____

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

Release Information To Via Christi:

St. Francis St. Joseph St. Teresa Behavioral Health Center
 Rehab Hospital

Attention: _____

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

SECTION 3 – Type of access requested _____ Copies 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 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: 929 N. St. Francis
Wichita, KS 67214

- Via Christi Hospital St Francis Via Christi Behavioral Health Center
 Via Christi Hospital St Joseph Via Christi Rehabilitation Hospital
 Via Christi Hospital St Teresa

Fax: 316.268.8697

