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

Mail to: 1947 Founders Circle
Attn: HIM Department
Wichita, KS 67206
or Fax to the following:

For Medical Records	For Radiology Images
Phone: 316-274-4995	Phone: 316-274-8852
Fax: 316-274-5371 / 316-274-5372	Fax: 316-274-8785

SECTION 1 - Demographic

Patient Name: _____ Date of Birth: _____

Patient Name at time of treatment (if different): _____ Telephone Number _____

Patient Street Adress: _____

City: _____ State: _____ Zip: _____

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

Release Information FROM:	Release Information TO:
Specify Facility and Address below, including phone/fax if known	Specify Facility and Address below, including phone/fax if known
_____	_____
_____	_____
_____	_____

SECTION 3 - Type of access requested

Specify dates of treatment: _____

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

❑ Abstract ❑ Consult Report(s) ❑ Office Visit Notes ❑ Medication Record
❑ Lab Reports ❑ Imaging/Radiology Reports ❑ Entire Record

❑ ONLY the following specified information: _____

I understand that requested information in my health record may include information relating to sexually transmitted disease, aquired immunodeficiency syndrom (AIDS) or human immunodeficiency virus (HIV). It may also include information about genetic testing, 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 signed Authorization

SECTION 5 - Purpose

Purpose for use or disclosure: (check one)

❑ Continued Care ❑ Insurance/Disability ❑ Litigation ❑ Personal ❑ Other (Specify)

SECTION 6 - Statment 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 have the right to inspect the health information I have authorized to be used or disclosed by this Authorization form.
- I understand that I may revoke this Authorization at any time by delivering a written revocation to the Health Information Management Department at 1947 Founders Circle, Wichita, KS 67206
- I understand that if I revoke this authorization, it will have no effect on disclosure 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)

Copy fees are set per the Kansas Department of Labor. Cost includes labor and supplies up to $18.97, plus $ .63 per page for the first 250 pages, and $.45 per page for every additional page. Actual postage or shipping costs also may be charged. Via Christi Clinic Copy Service is provided by HealthPort. If you have any questions or wish to check on the staus of your request please contact HealthPort customer service at 1-800-367-1500. Please allow 12 business days for processing.