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 Ascension Via Christi:**
❑ Manhattan

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

_____

_____

_____

Release Information **To Ascension 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 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 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 fax or mail this authorization to:

Ascension Via Christi Hospital Manhattan
1823 College Ave.
Manhattan, KS 66502
Fax: 706-842-7361

****For official Use.****

Requester ID: _____
Pages: _____
Initial & Date: _____
MRN/Acct#: _____