

**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:

Pittsburg

Release Information To Ascension Via Christi:

Pittsburg

Attention: \_\_\_\_\_

Attention: \_\_\_\_\_

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

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 by delivering a written revocation to the Health Information Management Department at 1 Mt. Carmel Way, Pittsburg, KS 66762.
- 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 Pittsburg  
1 Mt. Carmel Way  
Pittsburg, KS 66762  
Fax: 706-842-7361

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

Requester ID: \_\_\_\_\_

# Pages: \_\_\_\_\_

Initial & Date: \_\_\_\_\_

MRN/Acct#: \_\_\_\_\_

**M# Pt#**

