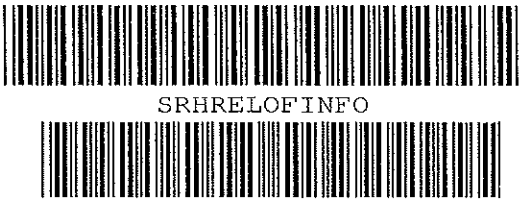
SALINA REGIONAL HEALTH CENTER HOSPITALS
AND AFFILIATED HEALTH CLINICS
AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION



( ) Cloud County Health Center	( ) Lindsborg Community Hospital	( ) Salina Regional Health Center
( ) Family Care Center	( ) Family Healthcare	( ) Pediatric Care
COMCARE	**( ) Memorial Health System**	( ) Podiatry
( ) Ohio	(X) Heartland Healthcare Clinic	( ) Pulmonary, Critical Care, Sleep Medicine
( ) Minneapolis	( ) Comprehensive Pain Solutions Clinic	( ) Surgical Associates
( ) Occupational Health Partners	**Salina Regional Health Center (SRHC)**	( ) Urgent Care
( ) Santa Fe	( ) Gastroenterology	( ) Women's Clinic
( ) Stat Care	( ) Heart Center	( ) Oncology.Hematology @ TWCC
( ) Endocrinology	( ) Neuroscience	( ) Orthopedic
	( ) Neurosurgery	( ) Other

Patient Information:

Patient Name:_____ DOB:_____ Social Security #:_____

Address:_____City,State,Zip Code _____

Phone #:_____ Specific date(s) of service (from – to):_____

Purpose: ☐ Personal ☐ Legal ☐ Disability ☐ Continuing Care ☐ Transfer of Care ☐ Other

Records to be sent to:

Name of person, doctor, or place: Heartland Healthcare Clinic

Address: 511 NE 10th City,State,Zip Code Abilene KS 67410

Phone #: 785-263-4131 Fax #: 785-263-2774

Records requested from:

Name of person, doctor, or place: _____

Address:_____City,State,Zip Code _____

Phone #:_____ Fax #:_____

Place an X by the PHI that you want to send or ask for:

__Patient name, address, insurance	__Progress Note(s)	__Workman comp report(s)	__Other_____
__History and physical	__Imaging/X-ray	__Employment exam	_____
__Discharge summary	__Lab test result(s)	__School/Sport physical	__All PHI, no billing
__Consultation(s)	__Medication list	__Physician order(s)	__All PHI, plus billing
__Procedure(s)	__Immunization(s)	__Patient billing	__Radiology film(s)

SRHRELOFINFO

SALINA REGIONAL HEALTH CENTER AFFILIATED HEALTH CLINICS
AUTHORIZATION FOR USE OR RELEASE OF MY PROTECTED HEALTH INFORMATION

Sensitive Information continued: You must Initial below for SRHC to send or ask for the following PHI:

HIV/AIDS test/treatment; Initial to release: _____ Sexually transmitted disease; Initial to release: _____

Drug/Alcohol problem; Initial to release: _____ Mental Health Information: Initial to release: _____

Genetic Testing; Initial to release: _____ Sexual assault; Initial to release: _____ Abortion; Initial to release: _____

I understand this authorization is voluntary. If I do not sign this form, my healthcare from SRHC and the payment for this healthcare will not be affected.

I understand once my protected health information (PHI) is released, it may no longer be protected from federal privacy regulations. My PHI may be redisclosed without my knowledge.

I understand I may see and copy the information on this form if I ask for it. I will get a copy of this form after I sign it.

I understand my request for PHI may be refused and I will be told in writing the reason. I may be able to have a neutral person review the refusal. SRHC will do what the neutral person says after review.

I understand this authorization will expire on: _____. If blank this authorization will expire one year from the date that this form is signed.

I understand that I may change my mind after I have signed this form. I can cancel this form anytime by sending a written letter to: Salina Regional Health Center, Privacy Officer at 400 S. Santa Fe in Salina, KS 67401. The cancel of this authorization will not cancel any actions SRHC took before I cancelled this consent and it was received by the Privacy Officer. SRHC Privacy Practices may be accessed at www.srhc.com.

When you have filled out and signed this form you may:

Mail to: Health Information Management (HIM)
Attn: Release of Information (ROI)
Salina Regional Health Center
400 S Santa Fe
Salina, KS 67401

Fax to: 785-452-7752 or bring to the SRHC HIM Department at: 400 S. Santa Fe in Salina, KS 67401

Please call 785-452-7032 to talk with an ROI staff member if you need help filling out the form or have questions. Do not sign this form until it is completed.

Signature of patient or patient's guardian or representative: _____ Date: _____

Print name if patient's guardian or representative: _____

Relationship to patient and basis of my authority to act:

_____

_____

Instructions for filling out: Authorization to Use or Disclose Protected Health Information (PHI) forms for Hospitals, Clinics and Veridian Behavioral Health forms.

1. **The boxed section –** Put an **X** next to the name of the hospital where you were a patient. (not needed for Veridian Behavioral Health)

2. **Patient Information –** Print, So it can be read, your name, birthdate, social security number, address, phone and give a beginning and ending date for the specific date(s) of service you want to request record(s) in formation. Example 1/1/2017 – 7/31/2017. Mark the appropriate purpose for requesting medical record(s).

3. **Records to be sent to** – Print the name of who or where you want your medical record information to be given/sent to, the address, city, state, and zip code, phone and fax number (if there is one).

4. **Records requested from** – Print the name of who or where your medical record information is located, the address, city, state, and zip code, phone and fax number (if there is one).

5. **Place a X by the PHI that you want to be sent** – Place an X on the line before each medical document that you want to be sent. Example X Progress Note(s).

6. **Sensitive Information** – Due to the Sensitive nature of the following PHI. You must initial below for SRHC to send or ask for the following type of medical record information.

7. **Acknowledgment Statements** – Read through the following acknowledgments. Put a date that you want the request to expire where it reads "I understand the authorization will expire on:" If this space is left blank the authorization will expire one year from the date you sign this form.

8. **Signature and Date** – Sign and date the form. If you are a representative, sign and print your name so it can be read, and give your relationship to the patient, Example:Mother,Father, and POA. Please Provide Proof of any type of Medical Power of Attorney or Guardianship paperwork.

Revised 04/2020