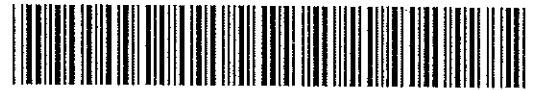


**SALINA REGIONAL HEALTH CENTER HOSPITALS  
AND AFFILIATED HEALTH CLINICS  
AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**



SRHRELOF INFO



<input type="checkbox"/> Cloud County Health Center	<input type="checkbox"/> Lindsborg Community Hospital	<input type="checkbox"/> Salina Regional Health Center
<input type="checkbox"/> Family Care Center	<input type="checkbox"/> Family Healthcare	<input type="checkbox"/> Pediatric Care
<b>COMCARE</b>	<input type="checkbox"/> Memorial Health System	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Ohio	<input checked="" type="checkbox"/> Heartland Healthcare Clinic	<input type="checkbox"/> Pulmonary, Critical Care, Sleep Medicine
<input type="checkbox"/> Minneapolis	<input type="checkbox"/> Comprehensive Pain Solutions Clinic	<input type="checkbox"/> Surgical Associates
<input type="checkbox"/> Occupational Health Partners	<b>Salina Regional Health Center (SRHC)</b>	<input type="checkbox"/> Urgent Care
<input type="checkbox"/> Santa Fe	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Women's Clinic
<input type="checkbox"/> Stat Care	<input type="checkbox"/> Heart Center	<input type="checkbox"/> Oncology.Hematology @ TWCC
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neuroscience	<input type="checkbox"/> Orthopedic
	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> 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: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Records requested from:**

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

Address: 511 N E 10<sup>th</sup> City, State, Zip Code Abilene KS 67410

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

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

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Patient name, address, insurance | <input type="checkbox"/> Progress Note(s)   | <input type="checkbox"/> Workman comp report(s) | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> History and physical             | <input type="checkbox"/> Imaging/X-ray      | <input type="checkbox"/> Employment exam        | _____  |
| <input type="checkbox"/> Discharge summary                | <input type="checkbox"/> Lab test result(s) | <input type="checkbox"/> School/Sport physical  | <input type="checkbox"/> All PHI, no billing   |
| <input type="checkbox"/> Consultation(s)                  | <input type="checkbox"/> Medication list    | <input type="checkbox"/> Physician order(s)     | <input type="checkbox"/> All PHI, plus billing |
| <input type="checkbox"/> Procedure(s)                     | <input type="checkbox"/> Immunization(s)    | <input type="checkbox"/> Patient billing        | <input type="checkbox"/> Radiology film(s)     |



SRHRELOFINFO

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

Page 2 of 2

**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](http://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