Authorization for Use or Disclosure of Protected Health Information (PHI)

HARRY HYNES MEMORIAL HOSPICE
316-265-9441
800-767-4965
hynesmemorial.org

Instructions:

- Please complete this 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 pencil.
- Refer to Harry Hynes Memorial Hospice Privacy Notice for additional Information.
- For further information please call the Health Information Management Department at 316-265-9441.

SECTION 1 - Demographic

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Cell: _____

SECTION 2 - Type of Access Requested **Copies of Record** **Inspection of Record**

Treatment date(s): _____

Please describe the specific Protected Health Information that may be used or disclosed:

__ Care Plans __ Medication Records __ Billing Statements

__ Nursing Notes __ Nursing Assessments __ Social Work Notes

__ History & Physical __ Bereavement Records __Entire Record

__ Other

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 3 - Identification of entity authorized to receive PHI

I hereby authorize Harry Hynes Memorial Hospice, 313 S Market, Wichita, KS 67202 to disclose medical records information and/or protected health information of the patient above to:

Facility, Covered Entity, Persons or Class of Persons: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

SECTION 4 - Expiration

This Authorization shall expire upon this date _____ or ____1 Year (Date cannot exceed 1 year)

SECTION 5 - Purpose **Purpose for use or disclosure**

__ Continued Care __ Personal __ Settlement of Estate

__ Insurance/Disability __ Legal __ 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 the potential for PHI to be re-disclosed at any time by the recipient and may no longer be 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, 313 S Market, Wichita, KS 67220.
- 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.
- Applicable fees may apply.

Signature of patient/legal representative: _____ Date: _____

Printed name of representative: _____

Relationship: _____