WESLEY Medical Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Instructions:

- Sections 1 – 6 must be completed. If any section is not complete, this authorization will be considered incomplete and not valid.
- Please print legibly.
- Refer to WMC Notice of Privacy Practices for additional information.
- For further information, please call Release of Information (316) 962-2513.

SECTION 1 – Demographic

Patient Name: _____ Birth Date: _____

Patient Name at time of treatment: _____

Patient Street Address: _____

City _____ State _____ Zip Code _____

Telephone Number – Home: _____ Work: _____ Fax: _____

Social Security Number: _____

SECTION 2 –Type of access requested

___ Copies of Record **___ Inspection of Record**

Treatment date(s): _____

Please describe what specific PHI may be used or disclosed:

___ Abstract/Pertinent	___ Consult Report	___ Physicians Orders	___Pathology Report
___ Face Sheet	___ Operative Report	___ Rehab Services	___Entire Record
___ Emergency Room	___ Cardiac Studies	___ Medication Record	Other _____
___ H&P	___ Lab	___ Nursing Notes	_____
___ Progress Notes	___ Imaging/Radiology	___ Discharge Summary	_____

SECTION 3 – Identification of Entity authorized to receive PHI

I hereby authorize **Wesley Medical Center, Department 840, 550 N. Hillside, Wichita, KS 67214,** to disclose medical records information and/or protected health information of the patient listed above to:

_____

(Facility, Covered Entity, Persons or Class of Persons) (Phone Number) (Fax Number)

_____

(Address) (City, State, Zip Code)

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: _____

SECTION 6 – Statements of Understanding

- I understand the potential for PHI to be re-disclosed by the recipient and may no longer be protected by federal privacy rules.
- I understand that I may revoke this authorization at any time by delivering a written revocation to the Health Information Management Department.
- If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
- I understand that I may refuse to sign this form. If I do not sign this form, my health care or payment for health care will not be affected.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or I am authorized to "Act on behalf of the patient as the patient's personal representative."
- Applicable fees may apply.

Signature of patient/legal representative: _____ Date: _____

Printed Name of representative: _____ Relationship: _____

TO BE COMPLETED BY HIM

I.D. verified by: _____ Date: _____

Information sent by: _____ Number of copies: _____ Date: _____