GIRARD Medical Center Health Information Management
GirardMedicalCenter.com
302 North Hospital Drive • Girard, KS 66743 • Phone 620.724.5140 • Fax 620.724.8886
#1 In Service

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Email: _____

I authorize Girard Medical Center (GMC) Hospitals and Clinics to (Check One):

☐ Release PHI **to** (GMC will SEND Records): ☐ Receive PHI **from** (Obtained from other facilities):

Authorized Person/Facility to Receive/Release PHI:

Name of Person/Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Fax Number: _____ Email: _____

Dates of PHI to be Released (Check One):

□ Past Year □ Two Years □ For Dates of Service _____/_____/_____ through _____/_____/_____

Types of PHI to be Released (check the appropriate boxes and include other information where indicated):

The type of information to be used or disclosed is as follows

□ Discharge Summary
□ Emergency Room
□ History and Physical
□ Operative Report
□ Clinic Office Visits
□ Consultation Report
□ Lab Reports
□ X-Ray and Imaging Reports
□ Inpatient Mental Health Records
□ Outpatient Mental Health Records
□ Billing Records
□ Immunization Records

□ Other: _____

This information for which I am authorizing disclosure will be used for the following purpose(s):

□ Personal Use
□ Treatment/Care
□ Legal
□ Other: _____

By Signing this Authorization, I understand that:

1. I understand that the information in my medical 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 for alcohol and drug abuse.
2. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.
3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Girard Medical Center staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
4. Treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this authorization.
5. I understand that questions regarding the disclosure of my records can be explained by contacting Girard Medical Center's Director of Health Information Management at (620) 724- 5139.
6. I am stating that I have read and understand this authorization, and any questions I have about this authorization have been answered.
7. Unless I specify differently, this authorization will expire within ***(1) year*** from the date on which it was signed.
8. This Authorization will expire one (1) year after the date on which it was signed, unless a specific date is provided below. Specific date: _____.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

_____
Printed Name of patient or legal representative

If signed by legal representative, relationship to patient: _____
(Legal documentation must be present either in the patient's chart or at the time of signing the release of information).

_____ _____
Signature of witness Date

*****If picking up records in person, please present a valid photo ID.*****