

Salina Pediatric Care

785-825-CARE (2273)

520 S. Santa Fe, Suite 120, Salina, Kansas 67401

**SALINA REGIONAL HEALTH CENTER
AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION**

PATIENT NAME	BIRTH DATE	SOCIAL SECURITY NO.
Patient Address		Patient telephone

I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT

I HEREBY AUTHORIZE _____, _____, _____
Previous Physician/ Facility City State

TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO: **Salina Pediatric Care**
Name of organization to which disclosure is to be made

For Treatment date(s): ALL DATES For the following purposes(s) at the request of patient for treatment

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED (Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)					
<input checked="" type="checkbox"/>	Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected)	<input checked="" type="checkbox"/>	Patient Demographic Information	<input checked="" type="checkbox"/>	Cardiac Studies
		<input checked="" type="checkbox"/>	Emergency Room Records	<input checked="" type="checkbox"/>	Physician Progress Notes
<input checked="" type="checkbox"/>	Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.	<input checked="" type="checkbox"/>	Admission History & Physical	<input checked="" type="checkbox"/>	Physician Orders
		<input checked="" type="checkbox"/>	Consultation Reports	<input checked="" type="checkbox"/>	Discharge Summary
	Other _____	<input checked="" type="checkbox"/>	Operative/Procedure Reports	<input checked="" type="checkbox"/>	Nursing Notes
		<input checked="" type="checkbox"/>	Lab Test Results		Billing Records
		<input checked="" type="checkbox"/>	Imaging/Radiology Reports		

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires. If this item is left blank, the authorization shall remain effective for one year from the date of signature.

I understand that the records to be used or disclosed pursuant to this authorization may contain information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S. A. § 65-6001 et seq. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

- Records relating to participation in any federally assisted drug and alcohol abuse program
- Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition
- Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to: Health Information Management, Privacy Office, 400 S. Santa Fe, Salina, KS 67401. Phone (785) 452-7313 Fax (785) 452-7312 (Note: Revocation is not effective for disclosures that have already been made)

Date Signature of Parent/Guardian

Printed Name of Parent /Guardian Parent/Guardian Relationship to Patient

Address of Parent/Guardian Telephone # of Parent/Guardian

Date Signature of Witness