ASCENTIST HEALTHCARE

☐ Ascentist ASC Merriam ☐ Cedar Oaks Surgery Center ☐ Ascentist Hospital ☐ Ascentist Physicians Group

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____DOB:_____Medical Record #_____

Address: _____

Telephone #_____E-mail Address and/or Fax #_____

I,_____, authorize _____
(Patient or Legal Representative) **(Name of physician / health care provider releasing records)**

to disclose to: ☐ Self OR:

Name or Facility:_____

Phone: _____ Fax:_____

Address: _____

Date(s) of Service: _____

Only the following specific information (check all that apply):

☐ Abstract	☐ Operative Reports	☐ EKG/EEG Reports
☐ History and Physical	☐ Radiology Reports	☐ Cardiac Testing (Holter, Echo, Stress, etc.)
☐ Discharge Summary	☐ Laboratory Reports	☐ Behavioral Health/Psychiatric Care
☐ Consultations	☐ Pathology Reports	☐ Immunization Records
☐ Progress Notes	☐ Clinic Records	☐ Billing Records
☐ ER Record	☐ Therapy Notes/Reports	☐ Other _____

Or:

☐ Entire Medical Record for specified date(s) of service: From:_____To:_____
("Present" equals date of signature)

Information to be released by: ☐ Paper ☐ CD/DVD ☐ Fax ☐ Secure Email: _____
(Please note: release method availabilities vary by Facility locations; some options may be unavailable)

I understand that information disclosed pursuant to this authorization may include information relating to the following*, **unless specifically restricted below:**
• Psychological / psychiatric conditions • Drug and/or alcohol abuse diagnosis and/or treatment
• HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing
• Genetic testing
**Please note: per State regulations, additional authorization may be required for certain conditions*

List any restrictions: _____

The purpose of the disclosure is: _____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect and/or receive a copy of the health information I have authorized to be used or disclosed and that I may be charged a reasonable fee for any copies of the medical records that I receive.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Expiration Date: This authorization is in effect until_____(I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year.)

Signature of Patient or Legal Representative(s):_____**Date:**_____/_____/_____
(Note: If patient is a minor child, both parents may be required to sign)

Printed Name(s):_____Relationship to Patient: _____
(if signed by other than patient)

Please mail all medical records to the following address:
Ascentist Healthcare
5101 College Blvd.
Leawood, KS 66211

Phone: 913-529-1807

Fax: 816-875-2597 or 913-754-2170