

Coffeyville Regional Medical Center

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(If authorization was requested by CRMC for a use or disclosure of protected health information (PHI) a copy of this signed form will be provided to the patient or their personal representative.)

I, the undersigned, authorize Coffeyville Regional Medical Center, Inc. to use and/or disclose protected health information as described below.

1. Patient's name, address and date of birth: _____

2. Person(s) or class of persons (entity) authorized to receive the information: (i.e. name of family/friend, lawyer, insurance company, hospital/physician) _____

3. Description of information that may be used/disclosed: (i.e. radiology, lab, op report, history & physical, discharge summary including date of service) _____

4. The information will be used/disclosed for the following purposes: (i.e. continuation of care, billing, personal) **(Not required if the disclosure is at the request of the patient or patient's authorized representative.)**

5. I understand 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 be protected by those regulations.

6. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization. **(Not required if the disclosure is at the request of the patient or patient's authorized representative.)**

7. I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. This authorization expires _____ **[Not to exceed one year from date of request].**

Signature of Patient or Patient's Authorized Representative

Date

Patient's Name

Name, address and telephone number of Patient's Authorized Representative (if applicable)

Relationship or Authority/Capacity to act on Patient's behalf

Witness

Coffeyville Regional Medical Center, Inc. 1400 W. Fourth Street, Coffeyville, Kansas 67337 ♦ 620-251-1200

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