Coffeyville Regional Medical Center
And Coffeyville Regional Medical Center Medical Associates

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. and Coffeyville Regional Medical Center Medical Associates to use and/or disclose protected health information as described below. (PLEASE PRINT CLEARLY)

1. Patient's name:_____D.O.B>_____/_____/_____
Address: _____
City and State:_____

2. Who will receive the records from CRMC or CRMC Medical Associates?_____
_____
_____

3. What records are to be released (document type including date of service)?_____
_____
_____

4. Why CRMC/CRMC Associates are releasing the records: ___ 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

GEN

_____
Printed Name of CRMC Employee Completing /Witnessing From