Blue Valley Hospital | Blue Valley Surgical Associates

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections of this authorization MUST be completed to be considered valid in accordance with 42 CFR Parts 160 and 164

Patient Information:

Last Name:	First Name:	MI:	Date of Birth:
Patient Name at time of treatment (if different)		Social Security Number:	
Address:	City:	State:	Zip Code:
Phone Number: ( )	Email Address (Optional):		

I request my Protected Health Information to be released from:

Organization/Name:_____ Attn: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number: ( ) Fax Number: ( )

I request my Protected Health Information to be released to:

Organization/Name:_____ Attn: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number: ( ) Fax Number: ( ) Date of Next appointment*: _____

*Please allow at least fourteen business days processing time before next appointment.

I request the following Protected Health Information to be released from my medical record(s):

	Weight Loss Clinic Notes		History & Physical(s)		Radiology Report(s) (X-Ray, MRI, etc.)
	Pain Clinic Notes		Operative Report(s)		Radiology film/media on disc ($15 fee may apply)
	Orthopedic Clinic Notes		Laboratory and EKG Report(s)		Other (specify)

Covering periods of healthcare from: Start Date: _____ to & including End Date: _____

Purpose of this request:

_____ Continued Care / Coordination of Care _____ Insurance, Disability or Legal** _____ Personal Use**

***** We reserve the right to charge the fees set by the State of Kansas K.S.A. 65-4971(b)***

Signature: By signing this authorization form, I understand that:

- **Requests for copies of medical records and/or non-document material may be subject to copying fees.**
- Protected health information (PHI) may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I authorize the release of these records.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form, unless the treatment is for the sole purpose for disclosure to a third party.
- This authorization is voluntary and I have the right to refuse to sign it. I have the right to revoke this authorization at any time. Revocation must be made in writing by notifying the original recipient of this authorization. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:_____
  If I fail to specify an expiration date/event/condition, this authorization will expire 180 days from the date of authorization.

_____ _____/_____/_____

Signature of PATIENT or AUTHORIZED REPRESENTATIVE* DATE OF AUTHORIZATION

_____ _____

PRINTED name of AUTHORIZED REPRESENTATIVE* AUTHORIZED REPRESENTATIVE'S relationship to patient

*If signed by a patient authorized representative, supporting legal documentation must accompany this authorization form.

Return completed authorization to:
Blue Valley Hospital – Health Information Management
12850 Metcalf Ave., Overland Park, KS 66213

Phone: (816) 207-7914
Secure Fax: (913) 378-1313
Attach Signed Authorization to E-Mail: ciox@moreoflife.com