Via Christi Clinic, P.A.
3311 E. Murdock
Wichita, KS 67208

For Medical Records
Phone: 316.613.4995
Fax: 316.613.5371

For Radiology
Phone: 316.689.9157
Fax: 316.689.9785

Authorization to Release Protected Health Information

Patient Name: ________________________ DOB: _________Email: ___________________________

Address: ________________ City:___________ State: ____Zip: ________Phone: _____________

I hereby authorize:

☐ Via Christi Clinic

☐ Other Physician (Specify) _______________

Address: _________________________________

City: _____________________________________

State: ______________ Zip:________________

Phone: _____________ Fax: _______________

To release to: (Required Information)

Name: ____________________________________

Address: __________________________________

City: ______________________________________

State: ________________Zip: ________________

Phone: ________ Fax: ______________________

Describe specific PHI you are requesting:

☐ Entire medical record

☐ Entire medical record for specified date(s) of service: From: ________ To: ________________

☐ ONLY the following specific information: ____

____

____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

- Psychological/psychiatric condition and psychotherapy notes
- Drug and/or alcohol abuse diagnosis and/or treatment
- Genetic testing
- HIV/AIDS diagnosis and/or testing
- Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: ____

____

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The purpose of the disclosure is: ____

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Via Christi Clinic is not responsible for the accuracy or completeness of records created by other health care providers.

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 re-disclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authoring 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 the health information I have authorized to be used or disclosed by this authorization form.

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: I understand this Authorization shall expire one (1) year from date listed above unless I indicate otherwise.

Noted here: ____

Per the Kansas Department of Labor: The patient or representative shall pay for the reasonable cost of obtaining a copy of his/her records including charges for labor and supplies not to exceed $18.97 plus $.63 per page for the first 250 pages, and $.45 per page for every additional page. Actual postage or shipping costs also may be charged. (Note: Radiology charges are based on metro area averages. Radiology film $8.00 per sheet.) 01/2012

Signature of Patient or Legal Representative(s): ________________________________

Date: __ / ___ / ______ Printed Name(s): __________________________________

Relationship to Patient:______________ (if signed by other than patient) Phone:_________________

Address: ____

City: ______________________________ State: _________ ZIP: __________

Via Christi Clinic Copy Service is provided by: HealthPort.

If you have questions, concerns or wish to check the status of your request please contact HealthPort customer service at 1-800-367-1500.

04/01/2014