Authorization Form

PATIENTS NAME	BIRTH DATE	ADDRESS

I HEREBY AUTHORIZE AND REQUEST HAYS MEDICAL CENTER (PLEASE INDICATE WHERE RECORDS LOCATED)

❑ **HOSPITAL** ❑ **CLINIC NAME** _____

TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE−NAMED PERSON TO:

_____

_____

Name(s) and address(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made.

Phone # of Recipient of Records *(REQUIRED)*:_____

For treatment date(s):_____

For the following purpose(s): _____

If the request is initiated by the individual (or his/her representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure

Delivery Method of Records: ***Check only ONE***

❑ Mail (Paper)
❑ Pick−up (Paper)
❑ Fax
❑ Mail CD/DVD (Digital)
❑ Email / Electronic (Digital)*
− *If checked please complete* →
* Will be emailed to patient ONLY

Email:_____

Preferred Password:_____
Must contain 8−12 characters

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED

Unless the appropriate box is checked, Hays Medical Center will not disclose records contained in its medical records prepared by health care providers not affiliated with Hays Medical Center unless the records were prepared on behalf of Hays Medical Center.

Demographic Information
❑ Hospital ❑ Clinic

Emergency Room Records
❑ Hospital ❑ Clinic

Admission History & Physical
❑ Hospital ❑ Clinic

Consultation Reports
❑ Hospital ❑ Clinic

Operative/Procedure Reports
❑ Hospital ❑ Clinic

Oncology Treatment Records
❑ Hospital ❑ Clinic

Lab Test Results
❑ Hospital ❑ Clinic

Physician Progress Notes
❑ Hospital ❑ Clinic

Physician Orders
❑ Hospital ❑ Clinic

Discharge Summary
❑ Hospital ❑ Clinic

Nursing Notes
❑ Hospital ❑ Clinic

Billing Records
❑ Hospital ❑ Clinic

Imaging/Radiology Reports
❑ Hospital ❑ Clinic

Imaging/Radiology Films/CD
❑ Hospital ❑ Clinic

Cardiac/Imaging Reports
❑ Hospital ❑ Clinic

Cardiac/Imaging Films/CD
❑ Hospital

❑ **PT/OT/ST/AT notes**

❑ **Prescription Records**

❑ **Other** _____
_____

❑ **Entire Record** (will not include Billing Records or records not prepared by or on behalf of Hays Medical Center unless those items also are selected).

❑ **Records not prepared by or on behalf of Hays Medical Center.** Hays Medical Center cannot be responsible for the completeness or accuracy of such records.

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, **but no later than one year from the date listed below**. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted **drug and alcohol abuse program**; information relating to diagnosis and treatment **of mental, alcoholic, drug dependency, or emotional condition**, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); information relating to **HIV testing, HIV status or AIDS.**
_____ **Initial here if you do not wish this information to be disclosed.**

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that 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 protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it or except as otherwise stated in Hays Medical Center's Notice of Privacy Practices by mailing or hand−delivering written notification to the following person: Privacy Officer, Hays Medical Center, 2220 Canterbury Drive, P.O. Box 8100, Hays, Kansas 67601.

_____ _____
Date/Time *Signature of Individual/Individual Representative*

_____ _____
Printed Name of Representative and Relationship *Representative address and telephone number*

_____ _____
Date/Time *Signature of Witness*

ORIGINAL − Hays Medical Center | COPY − Individual

HAYSMED

DOB: D A/Sdt:

Discrimination is Against the Law

Hays Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Hays Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hays Medical Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Hays Medical Center provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Director of Clinical Care Coordination at 785.623.5297, or the Operator at 785.623.5000.

If you believe that Hays Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Chief Legal Officer/Corporate Compliance Officer
Hays Medical Center
2220 Canterbury Drive
Hays, Kansas 67601
Telephone Number: 785.650.2759
TTY/TDD or State Relay Number: 800.766.3777 (V/T); or Dial 711
Fax: 785.623.5524
Email: joannah.applequist@haysmed.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joannah Applequist, Chief Legal Officer/Corporate Compliance Officer, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1−800−368−1019, 800−537−7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services are available to you free of charge. Call 1−855-429-7633 (TTY: 1−800-766-3777).

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1−855-429-7633 (TTY: 1−800-766-3777).

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1−855-429-7633 (TTY: 1−800-766-3777).

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1−855-429-7633 (TTY: 1−800-766-3777)。

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1−855-429-7633 (TTY: 1−800-766-3777).

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1−855-429-7633 (TTY: 1−800-766-3777) 번으로 전화해 주십시오.

LAOTIAN
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,

ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1 855-429-7633 (TTY: 1 800-766-3777).

ARABIC
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-855-429-7633 (TTY: 1-800-766-3777).

TAGALOG
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1−855-429-7633 (TTY: 1−800-766-3777)

BURMESE
သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်

စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 1−855-429-7633 (TTY: 1−800-766-3777) သို့ ခေါ်ဆိုပါ။

FRENCH
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1−855-429-7633 (TTY: 1−800-766-3777).

JAPANESE
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1−855-429-7633 (TTY: 1−800-766-3777)まで、お電話にてご連絡ください。

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1−855 429 7633 (телетайп: 1−800 766 3777).

HMONG
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1−855-429-7633 (TTY: 1−800-766-3777).

PERSIAN (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY: 1−800-766-3777) 1−855-429-7633 تماس بگیرید.

SWAHILI
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1−855-429-7633 (TTY: 1−800-766-3777).

HAYSMED

DOB: D A/Sdt: