SUMMIT HEALTHCARE

1818 E. 23rd Avenue
Hutchinson, KS 67502
Fax: 620-669-2394
Phone: 620-662-6000

Authorization for the Use and Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth**: _____ **SSN**: _____

Address: _____ **City:** _____**State/Zip:** _____

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Provider or Facility: Summit Healthcare

Address: 1818 E. 23rd **City:** Hutchinson **State/Zip:** KS, 67502

This information to be disclosed is as follows:

☐	Operative Report(s)	☐	Complete Health Records From: _____To: _____
☐	Laboratory Report(s)	☐	Pathology Report(s)
☐	Pinnacle Rehabilitation Records	☐	
☐	Other:		

Treatment Dates(s):_____ (Please list date range or specific date of service)

Purpose of Discloser: ☐ Share information with other providers involved in my care. ☐ Transfer of care

☐ Personal use/copy ☐Other: _____

This information may be disclosed to and used by the following individual or organization:

Name:_____

Address: _____**City:** _____ **State/Zip:**_____

Phone Number:_____ **Fax Number:**_____

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: Human Resources, HIPAA Privacy Officer, at Summit Healthcare, LLC. This authorization expires on _____ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I authorize the release of my records relating to (check one):

☐ Treatment rendered prior to the date this authorization is signed

☐ Treatment rendered both before and after the date this authorization is signed

☐ Treatment rendered only after the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulations. A photo static copy of this authorization shall be considered as effective and valid as the original authorization. I also understand fees may be charged for preparing and sending copies of records including charge for labor and supplies up to $18.97 per request and a copying charge of up to $0.63 for the first 250 pages and $0.45 for additional pages (K.S.A 65-4971(b)).

_____ _____ _____

Signature of Patient or Personal Representative **Printed Name** **Date**