THE MEDICAL CENTER

1100 North Main Street/ Hutchinson, Kansas 67501/ 620-669-6690 / Fax 620-669-6665

Authorization to Disclose Information to Those Involved in My Care

RE:____ ________________

Last Name (Maiden Name) First Name Middle Initial Date of Birth

____ (____)__________

Address City State Zip Phone#

I hereby allow the Medical Center, to disclose the following Protected Health Information:

- ☐ Appointment times and dates
- ☐ Tests that have been received
- ☐ Test results
- ☐ Other health information
- ☐ All information (health & billing)
- ☐ All health information
- ☐ Billing information -
  Specify dates____________________
- ☐ All billing information

to the following people because they are involved with my health care or payment, please print full name:

- ☐ Self
- ☐ Spouse ____
- ☐ Family friend ____
- ☐ Child ____
- ☐ Other ____

in the following forms of communication:

- ☐ Home telephone #_____________________________________
- ☐ Work telephone #______________________________________
- ☐ Home voice messaging system #___________________________
- ☐ Work voice messaging system #___________________________
- ☐ Cellular phone #______________________________________
- ☐ Other ___________________________

Signed:____ Date_____/_____/_____

Patient (or Legal Representative and Relationship)