CYPRESS
Surgery Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please print legibly and complete the form in full. Use only blue or black ink.

Section 1 – Patient Demographics

Patient Name _____ Date of Birth _____/_____/_____
Patient Name at time of visit (if different) _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Email _____

Section 2 – Identification of Entity/Persons/Class of persons authorized to receive PHI

Certification:
☐ Self ☐ Authorized Representatives Name _____ Relationship_____

I hereby authorize records FROM:	**To be released TO:**
☐ Cypress Surgery Center ☐ Specify Facility and Address below, including phone # and fax if known. _____ _____ _____	☐ Cypress Surgery Center ☐ Specify Facility and Address below, including phone # and fax if known. _____ _____ _____

Section 3 – Type of Access Requested

Specify Date range _____ to _____

Please describe the specific PHI you are requesting (*check all that apply*):
☐ Clinical Records ☐Operative Reports ☐ Billing ☐Lab/Pathology Reports ☐Complete Medical Record ☐Other: _____

Section 4 – Format of Information To Be Sent

☐ Paper - MAILED ☐ Paper – PICK UP ☐ Fax ☐ Encrypted Email

Section 5 – Expiration

Unless otherwise revoked, this Authorization shall expire no later than **ONE YEAR** from the date of this signed Authorization.

Section 6 – Purpose

Purpose for use of disclosure: (check one)
☐ Continued Care ☐ Insurance/Disability ☐ Litigation ☐ Personal ☐ Work Compensation
☐ Other (Specify): _____

Section 7 – Statement of Understanding

- I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign it.
- I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.
- I understand that the information in my medial record may include information relating to sexuality transmitted disease, Acquitted Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the renovation will not apply to my insurance company.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Printed Name** of Patient/Parent/Guardian or Authorized Representative **Date**

TO BE COMPLETED BY CYPRESS SURGERY CENTER MEDICAL RECORDS

Format Sent: ☐ Paper - Mailed ☐ Paper – Picked Up ☐ Fax ☐ Encrypted Email
Authorization(s) Included: ☐ Photo ID: Patient Or Authorized Representative ☐ Legal Authorization Paperwork (if applicable)

Completed by: _____ Date _____

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Obtaining Medical Records

Cypress Surgery Center is committed to protecting the privacy of our patients. Under federal law, we are required to document the disclosure of your information and to verify an individual's identity prior to releasing your records. Therefore, we have taken the necessary precautions to ensure your protected health information will remain secure.

The following forms of identification will be accepted when obtaining medical records

- State Driver's License
- State Identification Card
- U.S. Passport
- U.S. Naturalization Card
- U.S. Armed Forces Identification Card
- U.S. Selective Service Card
- U.S. Immigration Card

If you are planning on picking up your medical records, please contact our office ahead of time to avoid delays. An "Authorization for use or Disclosure of Personal Health Information" form will need to be completed to obtain any records. You may download this form online, request this form at the receptionist's desk, or by calling Medical Records at (316) 634-0404 Option 3.

All the information on the "Authorization for use or Disclosure of Personal Health Information" must be completed, in order to release Medical Records.

If you are requesting medical records on a deceased patient, you will need to provide a legal copy of the Power of Attorney, Executor of the Estate, or a death certificate showing next of kin to obtain the medical records.

If you are the Legal Guardian or have Medical Durable Power of Attorney, you will need to provide a legal copy of those forms in order to obtain the medical records.

Cypress Surgery Center has the following formats to complete your request for medical records:

- Paper Chart – Mailed
- Encrypted Email
- Fax
- Paper Chart – Picked Up in Person
  (With a valid ID)

After completing the release, you can return it to us at the office, by mail or fax.

Mailing Address:
Cypress Surgery Center
Attention: Medical Records
9300 E 29th Street North S-100
Wichita, Kansas 67226

Medical Records Fax:
(316) 854-5426

Once we receive the completed and signed release with proper identification, we can then process your request and send it as directed on the form. This process may take up to 30 days. Failure to complete all areas of the form and/or providing a copy of identification or legal authorization paperwork will delay your request.

If you have any questions, please give us a call at (316) 634-0404 Option #3.

Thank you,

Medical Records