ROMAN CATHOLIC DIOCESE OF SALINA
AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTH DATE

CHECK ONE:

BY SIGNING BELOW, I HEREBY AUTHORIZE ANY HEALTH CARE PROVIDER THAT HAS PROVIDED TREATMENT TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:

Catholic Chancery Office
103 N. 9th Street, P.O. Box 980
Salina, Kansas 67402-0980

For Treatment date(s):_____

Specify date(s) - this line MUST BE completed

For the following purpose(s): _____At the request of the patient_____

If the request is initiated by the patient (Or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Provider will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED (Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provides unless records were prepared on behalf of Provider	
☐	Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected)
☐	Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.
☐	Other _____

_____ _____

Date *Signature of Authorized Agent/Representative (Parent)*

_____ _____

Printed Name of Authorized Agent/Representative (Parent) *Relationship of Authorized Agent/Representative*

_____ _____

Address of Authorized Agent/Representative *Telephone # of Authorized Agent/Representative*

_____ _____

Date *Signature of Witness*

ORIGINAL - Privacy Officer COPY - Patient Medical Record

For Office Use Only: For each disclosure made pursuant to this authorization, list the name of the person/entity to whom the disclosure was made; a description of the disclosed; the date on which the disclosure was made; any fees charged in connection with the disclosure; and the name of the person making the disclosure.