HAYSMED

Patient Portal Authorization

PAWNEE VALLEY COMMUNITY HOSPITAL
HAYSMED PARTNER

To request access to your medical information via the Patient Portal, please complete this form in its entirety.

- This form is applicable to patients age 12 and older who are requesting access to their own medical information through the Patient Portal.
- If you wish to request proxy access (a proxy is a person who can access your Patient Portal account information as if they were you), please use the appropriate proxy request form instead.
- Adults with diminished capacity may have their legal guardian request proxy access by using the proxy request form.
- This authorization for access is valid until rescinded by the patient, death, or any statutory or regulatory requirement automatically allows the authorization to expire.

PATIENT INFORMATION

First Name:_____ Last Name:_____ Sex: ❑ M ❑ F

Date of Birth:_____ Last 4 Digits of your Social Security #:_____

Address:_____

Previous Names (if applicable):_____

Phone #:_____ Email Address:_____

Authorization to Release Protected Health Information in the Patient Portal
To be completed by the patient age 12 or older.

I authorize HaysMed and/or Pawnee Valley Community Hospital to release my medical information via the Patient Portal.

- The following information is to be released: All information as allowed through the Patient Portal (note: the Patient Portal may not contain the complete medical record).
- If at any time I no longer wish to have a Patient Portal account, I can contact the Health Information Management Department at 785−623−5151 to deactivate my Patient Portal.
- I understand that the information in my health record may include information relating to reproductive concerns, sexually transmitted infections, acquired 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 authorize the release of these records.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized 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 Health Information Management Department at 785−623−5824.
- I understand this authorization must be filled out completely and signed, dated, and timed in order to be considered valid. My authorization may also be provided over the phone. Completion of this request will be completed within three (3) business days. I understand that I may be contacted by a staff member to verify this information.
- I represent that I am twelve (12) years of age or older and have the legal authority to sign this authorization.

_____ _____
Signature of Patient Age 12 years or older Date/Time

For Office Use Only:
❑ Verbal consent obtained via phone
by Associate:_____
Date/Time: _____

Date Enrolled:_____
Initials: _____