Anesthesia Associates of Central Kansas, P.A.

200 S. 5th Street Suite A
Salina Ks 67401
Phone 785-827-2238 Fax 785-823-0828
www.aack.org
Please contact our office with any questions. Thank you!

Authorization for use of Protected Health Information

Printed Name of Patient | Patient's Date of Birth | Patient's Social Security #

Printed Name of Person Submitting Request (if other than patient) | Relationship to Patient

Authorization to release information:
I hereby authorize Anesthesia Associates of Central Kansas, its physicians and/or staff to share verbally or otherwise diagnostic reports, other medical information, and all relevant portions of medical record information about me or the above names patient for whom I possess parental custody or other legal authority to:

First and Last Name	Relationship to Patient	Phone Number	Allow Messages? Yes No
			Yes No
			Yes No
			Yes No
			Yes No

ALTERNATE COMMUNICATIONS:
I hereby authorize Anesthesia Associates of Central Kansas to contact me via the following methods of communication with regard to my Protected Health Information (PHI) or the PHI of the above named patient (this includes, but is not limited to, appointments, test results, etc.).
NOTE: Please indicate the preferred order of contact for each of the alternate communication items listed below (i.e. indicate "1" for FIRST preference, "2" for SECOND preference, "3" for THIRD preference, etc.).

Pref #		May messages be left at this number?	Yes No
_____	Home Phone Number		
_____	Day Phone Number	May messages be left at this number?	Yes No
_____	Cell Phone Number	May messages be left at this number?	Yes No
_____	Other (please include description)	May messages be left at this number?	Yes No

I understand that this authorization will be in effect for the duration of treatment and follow up unless terminated by me in writing.

Patient Signature or Patient Representative Signature | Date

Revised 3/2018