**Patient Name: Birth Date**:

I authorize the use and/or disclosure of the above named individual’s protected health information as described below.

Information will be released to: Jayhawk Patient Supply 2860 SW Mission Woods Drive, Topeka Kansas 66614

Jayhawk Pharmacy and Patient Supply

(Specify name and/or title of individual at Jayhawk Patient Supply)

Jayhawk Patient Supply is authorized to make the disclosure:

* I understand this authorization is voluntary.
* I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
* In understand that if the person or organization listed below is not a health care plan or provider, federal privacy laws may no longer protect the released information.
* I understand that I may revoke this authorization at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization. (contact Jayhawk Patient Supply for instructions on how to revoke authorization)

Information to be released (check box): **\_X\_\_** Health Records \_\_**X**\_ Physician Order(s) \_\_\_ Financials

\_\_\_ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Oxygen Transfers, we also need: CMN, saturations, delivery ticket, pickup ticket,

**\_\_X\_ CPAP Transfers, we also need: sleep study, original prescription, face to face prior to sleep study, original delivery ticket for equipment, 90 day compliance followup (download and chart notes), and type and date of last supplies issued.**

I understand that the information in my health record may include information related to infectious disease; sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). This disclosure may also include information about behavioral or mental services, and the treatment of alcohol and drug abuse.

Printed Name Relationship to Patient

Signature or patient or representative Date of authorization