Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with South Central Kansas Medical Center. This form when signed allows South Central Kansas Medical Center to this authorized person about your personal information concerning insurance benefits, payments, treatment or any other health care information regarding your care.

_____ _____ _____ ____/____/_____ _____

First Name M Last Name DOB SSN#

I hereby give my consent for to communicate South Central Kansas Medical Center personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to South Central Kansas Medical Center P.O. Box 1107 Arkansas City, Kansas 67005. This authorization allows South Central Kansas Medical Center staff to speak with the authorized person(s) regarding: Treatment, insurance, benefits, copays or any other aspects regarding care. This form **does not** allow access to the patient's medical record. This form **excludes** any communication on patients that are in a confidential status.

Signature: _____ Date: _____ Time: _____

Person(s) Authorized to speak with South Central Kansas Medical Center:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Witness: _____Date: _____ Time: _____

South Central Kansas Medical Center
6401 Patterson Parkway
P.O. Box 1107
Arkansas City, KS 67005
Phone: 620-441-5995
Fax: 620-441-5982