

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

****This Form must be completed in its entirety to be accepted****

Patient Name: _____ Medical Record #/SS#: _____

Date of Birth: _____ Phone: H) _____ W) _____

Address: _____ City/State/Zip: _____

Please Note: This medical practice contracts with DMRS to copy and provide all medical records requested from their facility. We reserve the right to charge the fees set by the State of Kansas K.S.A. 65-4971(b) and the State of Missouri MRS 191.227. By signing this authorization, you are agreeing to pay DMRS for your records.

Above listed patient authorizes the following healthcare facility to make record disclosure:

Leawood Family Care PA

11301 Ash Street

Leawood, KS 66211

Telephone: (913) 338-4515

Fax: (913) 338-4606

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, 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.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Street/Suite: _____

City/State/Zip: _____

Fax: _____ Phone: _____

Dates and Type of info to disclose:

2 yrs prior from last date seen

Specific Info:

Purpose of Disclosure:

I understand that I have a right to revoke this authorization at any time in writing to Attn: HIM Dept. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure 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 authorized individual or organization making disclosure. @ 800-359-8520 #1

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____
Signature of Patient / Parent / Guardian or Authorized Representative

Date

**Complete if signed
By someone other
Than patient.**

Printed name of Authorized Representative

Relationship / Capacity to patient

Address and telephone number of authorized representative

(Guardian or Authorized Representative must attach documentation of such status.)