AUTHORIZATION FOR RELEASE OF MEDICAL 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
7025 College Blvd., Suite 200
Overland Park, 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 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 years 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 one 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 the information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If you have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure @ 800-359-8520 #1. Diversified Medical Records Services.

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 document of such status.)