LEAWOOD FAMILY CARE, P.A.
7025 COLLEGE BLVD., SUITE 200, LEAWOOD, KS 66211
T. 913-338-4515 F. 913-338-4606

MEDICAL RECORDS RELEASE OF INFORMATION

Patient Name_____ Date of Birth_____

Address_____ City/State/Zip_____

Telephone H_____ Cell_____

The following individual/organization is authorized to make the disclosure:

Physician/Medical Office_____ Phone/Fax_____

Address/Suite_____ City/State/Zip_____

The purpose of disclosure:
____ Change of Physician
____ Continuation of Care (i.e. Specialist)
____ Referral
____ Other_____

Type and amount of information disclosed:
____ 2 years back with most recent test results
____ 5 years back with most recent test results
____ Specific information_____

RESTRICTIONS: Only medical records that have originated through this health care facility will be photo copied unless otherwise requested. The authorization is valid only for the release of medical information dated prior to and including the date of the patient signed authorization.

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 include information about behavioral or mental health services and treatment for alcohol and drug abuse.

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

Release to: Leawood Family Care
7205 College Blvd, Suite 200
Overland Park, KS 66211

____ Please mail copies to address provided
____ I am planning to pick up the copies

I understand I have the right to revoke this authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 I year from the date signed,

I understand 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 I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR164.524. I understand any disclosure of 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 the disclosure.

I have read the above foregoing authorization for release of information and do hereby acknowledge I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Date Signature of Patient/Parent/Guardian or authorized representative

_____ _____
Witness Printed name of authorized representative and relationship to patient