

Medical Record Release Of Information

(A photocopy charge will be incurred for ALL requests)

Patient Name: _____ Social Security # _____

Date of Birth: _____ Telephone: Home: _____ Work: _____

Address: _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below.

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

Physician/Clinic: NEUROLOGY CONSULTANTS, CHARTERED Phone: 913-384-4200
Address: 8800 W. 75th Street, Suite 100 Fax: 913-384-1542
City, State, Zip Code: Shawnee Mission, KS 66204

The type and amount of information to be used or disclosed is as follows:

- 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 photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the 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 also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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

To release to: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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 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.

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.

(Date)

(Signature of Patient)

(Date)

(Signature of Parent, Guardian, or Authorized representative.)

If signed by a patient's authorized representative: _____
Printed name of authorized representative Relationship/Capacity to Patient

Address and phone number of authorized representative