Medical Record Release Authorization

Patient name:____ Birth Date: _________________________________

Maiden name: ____ Social Security #:_____________________________

Patient Address: ____

City: ______________________________ State: _________ Zip Code: ____________________

Home phone: ________________________Cell: ________________________Work: ________________________

I hereby authorize records **FROM**:

Facility or Physician:_________________________________

Address:____

City/State/Zip:______________________________________

Phone:______________________Fax:_________________

To be released **TO**:

Andover Family Medicine

2117 N. Keystone Circle

Andover, KS 67002

Phone (316) 733-5120 Fax (316) 733-1280

Purpose of the request:

_______ Transfer or Continuity of Care _______ Self/Personal Copy _______ Insurance _______ Litigation

_______ Disability _______ Work Comp _______ Other:____

Records requested:

What specific records may be disclosed: Date Range: __________________to____________________

_______ Physician Office Notes
_______ Radiology/X-Ray/MRI Reports
_______ Operative/Procedure Reports
_______ Lab/Pathology Reports
_______ Cardiology/EKG Reports
_______ ER Reports
_______ Immunizations
_______ Entire Record

Expiration

This authorization will expire one year from the date below unless I specify an earlier expiration date: ___________________

Statement of Understanding

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 any disclosure of information carries with it the potential for an unauthorized re-disclosure 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 understand that the information in my medical 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.

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. 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.

I am the patient listed or I am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient/Legal Representative: ____ Date: ________________

Printed Name: ____ Relationship: ________________

We reserve the right to charge the medical record state fee structure as set forth in the state statute.