

Patient Information

Full Name _____ Date of Birth _____
 Maiden or Other Names Used _____ Social Security Number: XXX-XX-____ (last 4 digits)
 Address _____
 Day Phone # _____ Cell # _____ City _____ State _____ Zip _____

Release From

- Hospital:** University of Kansas - St. Francis Campus 1700 SW 7th Street Topeka, KS 66606
- Tallgrass Ambulatory Surgery Center** 6001 SW 6th Ave. Topeka, KS 66615
- Clinic:** Name: _____ Street Address: _____

Release To

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Person/Company/Organization Name _____
 Address _____
 Phone # _____ Fax # _____ City _____ State _____ Zip _____

Purpose

- Continuation of Care Insurance/WC Legal
- Personal Other (specify): _____

Date(s) Of Information To Be Released

Date(s) of Service from _____ through _____
 Date(s) of Service from _____ through _____

Information To Be Released/Accessed

I would like copies of the items checked below for the treatment dates listed above.

- Emergency Report Discharge Summary History & Physical Imaging CD/Film (MRI/CT/X-Ray/Ultrasound)
- Operative Report Consultation Laboratory Imaging Report
- Clinic Visit Billing Records Cardiac Studies/EKG Other: _____

Disclosure/Access Format

I would like copies of the items checked above in the following format: (Paper format-US Mail is default if not marked)

- Paper format – US Mail CD Fax (healthcare provider only)
- Paper format – pick up Review only Email to: _____
- MyChart

Patient Access Information

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
- A Care Site professional will supervise the review of my medical record.
- If I am involved in a research study involving medical treatment, my access to the research study content may be temporarily suspended for as long as the research is in progress. At the completion of the research, access to my medical record will be reinstated.

I Understand That

- The information to be released may include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case **redisclosure is prohibited** under 42 CFR Part 2.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this care site may charge for copies of medical records.

Signature of Patient/Guardian/Personal Representative _____ Relationship (if not patient) _____ Date _____

Personal Representative's PRINTED Name, Address, and Phone Number _____

If patient is unable to sign, document reason: _____

For Office Use Only

Date Authorization Received: _____ By: _____ Identification/Driver's License # Verified: _____
 Date Request Completed: _____ By: _____ Delivery Instructions: _____



Authorization for Release/Disclosure of Protected Health Information (PHI)

PATIENT INFORMATION

Place label here.
 Scanning does NOT work if label is outside this guide.