Kansas City Ob Gyn

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Consent for Release of Medical Information

From Kansas City Ob Gyn to an outside facility

I,_____,DOB:_____,

authorize and request *Kansas City Ob Gyn* to disclose my medical records to:

Dr._____

Physician's address: _____

City/State: _____Zip: _____

Phone: _____Fax: _____.

The medical records requested include dates of service from: _____to _____.

Records to be released for the purpose of _____.

- All medical records EXCEPT those relating to care and treatment for mental health conditions, drug or alcohol abuse, or HIV testing, Infection status or care/treatment for AIDS.
- All medical records. **(Last two years only unless otherwise specified)**
- Specific information: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization in writing at any time, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, then the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.
6. I may receive a copy of this form after I sign it.

I have read the above statements and authorize the disclosure of the protected health information as stated. This consent expires on _____

Signature of Patient/Patient's Representative: _____Date: _____

Name of Patient's Representative_____Relationship _____