KC D PC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth**: _____

I, the above listed patient, am requesting my records be sent to my healthcare provider and authorize the following healthcare facility to make record disclosure:

Kansas City Direct Primary Care
7199 W 98th Terrace, Suite 110 Overland Park, KS 66212
913-730-0331 | info@kansascitydirectprimarycare.com | (no fax)

Dates and types of information to disclose:

[ ] 2 years prior to the last date seen
[ ] Date range:
_____

[ ] Specific type of information requested:
[**X**] Clinic visits, specialist visits, & ER visits; pathology, laboratory, microbiology & imaging results; meds

The purpose of disclosure is:

[ ] change of insurance [ ] referral [**X**] continuation of care [ ] other: _____

NOTICE: Only medical records originated through Kansas City Direct Primary Care will be copied unless otherwise specifically requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. 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 and used by the following individual or organization:

Release to: _____

Address: _____

Phone: _____ Fax: ___(please provide secure email)___

Email: _____

Please: [ ] mail records (*charges apply*) [ ] fax record [x] email records

I understand I may 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 Kansas City Direct Primary Care. 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.

Signature: _____ Date:_____

Printed Name: _____ Relationship to patient: _____

If not signed by the patient, address and telephone number of authorized representative: