Family Physicians of Kansas, LLC
524 N Andover Rd
Andover, KS 67002
Phone: 316-733-0716
Fax: 1-877-545-6391

Medical Record Release Authorization

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Patient Name at time of treatment: _____

Address: _____ City/State/Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

A.) I hereby authorize records FROM:

Practice/Facility Name_____

Provider/Physician Name_____

Address_____

City/State/Zip_____

Phone # _____ Fax# _____

B.) To be released TO:

Practice/Facility Name_____

Provider/Physician Name_____

Address_____

City/State/Zip_____

Phone # _____ Fax# _____

C.) For the purpose of:

_____ Transfer of Care
_____ Disability
_____ Litigation
_____ Self/Personal Copy
_____ Insurance
_____ Work Comp
_____ Other (Please Specify)_____

D.) Please Release:

_____ Entire Record
_____ Immunizations
_____ Physician Office Notes
_____ Lab/Path Reports
_____ Radiology/Xray/MRI Reports
_____ Cardiology/EKG Reports
_____ Operative/Procedure Reports
_____ Other (Please Specify)_____

Statements of Understanding:

- I understand the potential for PHI to be re-disclosed by the recipient and may no longer be protected by federal privacy rules.
- I understand that I may revoke this authorization at any time by delivering a written revocation to medical records.
- If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
- I understand that I may refuse to sign this form. If I do not sign this form, my health care of payment for healthcare will not be affected.
- I authorize the use of disclosure of the records/information described. I have read and understand this form. I have received a copy of this form, if requested. I am the patient listed or I am authorized to "act on behalf of the patient as the patient's personal representative."
- Applicable fees may apply.

Signature of Patient/Legal Representative:_____ Date: _____

Printed Name of Representative: _____

Representative Relationship to Patient: _____

This Authorization shall expire upon this date:_____ or _____1 year.