Medical Records Release Form

Patient Name:	**Date of Birth:**	**Patient Phone:**	**Last 4 digits SSN** (optional):

The following individual/organization is authorized to disclose my information:
Physician/Hospital: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone Number:______________________ Fax Number: ______________________

This information may be disclosed and used by the following individual/organization:
Physician Group: Mobile Anesthesia Care/MAC Wellness Center
Address: 8717 W. 110th St. Suite 600
City, State, Zip: Overland Park, KS 66210
Phone Number: (913) 428-2939 Fax Number: (913) 428-2784

This authorization will expire on the following: (Fill in the Date or the Event, NOT BOTH)
Date: Event:

Purpose of Disclosure:

Description of information to be used or disclosed:

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need:

Description:	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record ☐ Dictation reports ☐ Physician Orders ☐ Medication sheets		☐ Diagnostic Testing (MRI, CT scans, EKG, etc) ☐ Laboratory test results ☐ Itemized Bill ☐ Other: ______________________	

I acknowledge, and hereby consent to such, that released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV Results or AIDS information. ______________ (initial).

I understand that:

1. I may refuse to sign this authorization and this it is strictly voluntary.
2. If I do not sign this form, my health care and payment for health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable fee, if I ask for it.
6. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	Relationship to Patient: